SFY 2021

ANNUAL REPORT

WYOMING DEPARTMENT OF HEALTH
WYOMING MEDICAID

GOVERNOR MARK GORDEN
DIRECTOR STEFAN JOHANSSON
INTERIM MEDICAID STATE AGENT JAN STALL


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Stefan Johansson
Director

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Governor

April 1, 2022

Dear Medicaid Providers, Members, Stakeholders, and Wyoming Residents:

State Fiscal Year 2021 (July 1, 2020 to June 2021) was a busy and interesting year for Wyoming Medicaid, with the primary focus of the year being Medicaid's support and treatment of individuals with COVID-19, immunization efforts, and continued support of Wyoming providers during this difficult time.

Since the end of SFY 2021 to the date of this report, two major events have occurred that are worth noting. The first is retirement of long-term State Medicaid Agent Teri Green on January 14, 2022. All of us with Wyoming Medicaid appreciated the leadership provided by Teri and while sad she is no longer here, wish her a joyful retirement. Jan Stall, Provider and Benefit Management Administrator, was named Interim State Medicaid Agent on January 18, 2022. The second major event was the transition to a new Fiscal Agent and the launch of the new Benefit Management System on October 25, 2021, which was the culmination of multiple years of work and planning.

Other Medicaid highlights are listed below.

- With the ongoing public health emergency (PHE), the Medicaid program continued to make adjustments to policy and reimbursement rates based on the Centers for Medicare & Medicaid Services' (CMS) guidance.
- Phase 2 state budget cuts resulted in reimbursement rate reductions for developmental disabilities waiver and prescription drug programs and reduced the state supplemental payment for SSI clients to $20 regardless of living arrangement. Chiropractic services were eliminated, and the PACE (program for all-inclusive care of the elderly) program for Laramie county was discontinued.
- CMS approval was received for implementing the Profession Services Supplemental Payment Program and first program payments are in process.
- CMS approval for a 5-year renewal of the Community Choices Waiver (CCW) programs.
- A new vendor began providing services for Medicaid Eligibility and their customer service center (CSC) in October 2020, with a unified client call center launching in October 2021.
- Contracts were extended for Indian Health Services (IHS) and executed for the new health management/utilization management (HM/UM) vendor.
- The Wyoming Integrated Next Generation System (WINGS) project to replace and modularize the state Medicaid software system saw the Provider Enrollment and Screening and Monitoring (PRESM) module go live in April 2021.
- The data warehouse for Medicaid reporting continues to evolve with the additional integration of WES (Wyoming Eligibility System) data.

Many details, including expenditure and program utilization numbers, are provided for Medicaid programs in this report. Questions may be directed to the Wyoming Department of Health's Division of Healthcare Financing (307-777-7531).

Best regards,

Jan Stall

Jan Stall,
DHCF Interim Senior Administrator & State Medicaid Agent

TABLE OF CONTENTS

TABLE OF CONTENTS I
LIST OF FIGURES III
LIST OF TABLES IV
AT A GLANCE 1
- Enrollment 1
- Expenditures 2
- Recipients 2

BACKGROUND 2
- Financials & Funding 4
- Advisory Groups 6
- Program Integrity (PI) & Third-Party Liability (TPL) 7
- Demographics 7
- Economy 8

HIGHLIGHTS & INITIATIVES 9
- Program Updates 9
- Policy 9
- Technology 9
- Tribal Health 10
- Wyoming Integrated Next Generation System 10

ENROLLMENT 12
- By County 14

EXPENDITURES 15
RECIPIENTS 16
ELIGIBILITY CATEGORIES 17
SERVICES 20
- Overview 20
- Details 26
  - *Ambulance* 26
  - *Ambulatory Surgery Center* 27
  - *Behavioral Health* 27
  - *Care Management Entity* 29
  - *Clinic / Center* 30
  - *Dental* 30
  - *Durable Medical Equipment, Prosthetics, Orthotics, & Supplies* 31
  - *End-stage renal disease* 32
  - *Federally Qualified Health Center* 33
  - *Home Health* 33
  - *Hospice* 34
  - *Hospital* 35
    - *Inpatient Services* 37
    - *Outpatient Services* 37
    - *Emergency Room Services* 38
  - *Intermediate care facility for individuals with intellectual disabilities* 40
  - *Laboratory* 41
  - *Nursing Facility* 41
  - *Program for All-Inclusive Care for the Elderly (PACE)* 43
  - *Physician & Other Practitioner* 43
  - *Prescription Drugs* 45
  - *Psychiatric Residential Treatment Facility (PRTF)* 46
  - *Public Health or Welfare* 47
  - *Public Health, Federal* 48
  - *Rural Health Clinic* 48
  - *Vision* 49

Waivers *50*
Home & Community Based Services Waivers *50*
Community Choices Waiver *53*
Comprehensive Waiver *54*
Supports Waiver *55*
Pregnant By Choice Waiver *56*
SUBPROGRAMS &SPECIAL POPULATIONS 57
Subprograms 57
Drug Utilization Review *57*
WYoming Frontier Information (WyFI) Health Exchange *58*
Promoting Interoperability Program *58*
Administrative Transportation *59*
Patient-Centered Medical Home (PCMH) *59*
Project Out *60*
Health Check *60*
Special Populations 61
Medicaid/Medicare Dual Enrolled *61*
Foster Care *65*
APPENDIX A: SUPPLEMENTAL TABLES 67
Services 67
Births 68
County Data 69
Providers 70
APPENDIX B: REIMBURSEMENT METHODOLOGY 81
APPENDIX C: ELIGIBILITY REQUIREMENTS AND BENEFITS 91
APPENDIX D: GLOSSARY & ACRONYMS 95
Glossary 95
Acronyms 99
APPENDIX E: DATA METHODOLOGY 101
Enrollment 101
Recipients 101
Expenditures 101
Per Member Per Month 101
Services 101
Data Parameters 107

LIST OF FIGURES

Figure 1. Enrollment History: Monthly Average 1
Figure 2. Enrollment History: Monthly Average and Unique Enrollment 1
Figure 3. Wyoming Department of Health Organization Chart 3
Figure 4. Health Care Financing Expenditure History 5
Figure 5. Health Care Financing Funding History 5
Figure 6. Enrollment History: Monthly Average 12
Figure 7. Enrollment History: Unique and Monthly Average 12
Figure 8. Monthly Medicaid Enrollment by State Fiscal Year 13
Figure 9. Wyoming County Map by Medicaid Enrollment 14
Figure 10. Expenditure History 15
Figure 11. Top Services Expenditures as % of Total Medicaid Expenditures SFY 2021 vs SFY 2020 15
Figure 12. Recipient History 16
Figure 13. Recipient Utilization versus Expenditure Breakdown by Service Type 16
Figure 14. Enrolled Members versus Expenditures by Eligibility Category - SFY 2021 17
Figure 15. SFY 2021 Top Services by Expenditures 22
Figure 16. One-Year Change in Expenditures for Top Services 22
Figure 17. Percent of Unduplicated Recipients by Service 22
Figure 18. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Dementia and Alzheimers) 28
Figure 19. Hospital Inpatient-Outpatient Breakdown History by Expenditures 37
Figure 20. Emergency Room Utilization vs Total Medicaid by Eligibility Category 39
Figure 21. State General Funds-Court Ordered Psychiatric Residential Treatment Facility (PRTF) Placement (Services with Incorrect Language or No Medical Necessity) Summary 47
Figure 22. Waiver vs Non-Waiver Expenditures History 51
Figure 23. Total Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers 52
Figure 24. Non-Waiver Services Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers 52
Figure 25. SFY 2021 Waiver-Only versus Non-Waiver Services by Waiver 53
Figure 26. SFY 2021 Total Waiver Expenditure Breakdown by Waiver 53
Figure 27. Dual Enrolled Claims Coverage Process 61
Figure 28. Dual Enrolled as Percent of Total Medicaid in SFY 2021 62
Figure 29. History of Dual Enrollment and Expenditures as Percent of Total Medicaid 62
Figure 30. History of Crossover Expenditures as Percent of Total Dual Expenditures 62
Figure 31. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2021 62
Figure 32. Percent of Total Unduplicated Dual Recipients by Service 64
Figure 33. Dual Expenditures as Percent of Total Medicaid Expenditures by Service 64
Figure 34. Percent of Foster Care Expenditures by Service - Medicaid versus State-Only 66

LIST OF TABLES

Table 1. Division of Healthcare Financing Expenditures for SFY 2021 4
Table 2. Wyoming Medicaid Advisory Groups and Committees 6
Table 3. Employment and Mean Wages by Occupation 8
Table 4. Change in Medicaid Enrollment 13
Table 5. Medicaid Enrollment by County 14
Table 6. Expenditure History by Service Type 15
Table 7. Recipient History by Service Type 16
Table 8. Eligibility Category Summary 18
Table 9. Enrollment History by Eligibility Category 18
Table 10. Expenditures History by Eligibility Category 19
Table 11. Unique Recipient History by Eligibility Category 19
Table 12. Covered Services 20
Table 13. Service Utilization Summary 21
Table 14. Expenditure History by Service 23
Table 15. Expenditure History by Other Services 24
Table 16. Recipient Count History by Service 25
Table 17. Ambulance Services Summary 26
Table 18. Ambulatory Surgery Center Services Summary 27
Table 19. Behavioral Health Services Summary 28
Table 20. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types 29
Table 21. Care Management Entity Services Summary 29
Table 22. Clinic/Center Services Summary 30
Table 23. Dental Services Summary 31
Table 24. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary 32
Table 25. End-Stage Renal Disease Services Summary 32
Table 26. Federally Qualified Health Center Services Summary 33
Table 27. Home Health Services Summary 34
Table 28. Hospice Services Summary 35
Table 29. Total Hospital Services Summary 36
Table 30. Inpatient Hospital Services Summary 37
Table 31. Outpatient Hospital Services Summary 38
Table 32. Emergency Room Utilization Summary 38
Table 33. Emergency Room Utilization by Eligibility Category 39
Table 34. Emergency Room Utilization vs Total Medicaid by Eligibility Category 40
Table 35. Intermediate Care Facility for Individuals with Intellectual Disabilities Services Summary 41
Table 36. Laboratory Services Summary 41
Table 37. Nursing Facility Services Summary 42
Table 38. Program for All-Inclusive Care for the Elderly Services Summary 43
Table 39. Physician and Other Practitioner Services Summary 44
Table 40. Prescription Drug Services Summary 45
Table 41. Pharmacy Cost Avoidance - SFY 2021 45
Table 42. Prescription Drug Rebates History 46
Table 43. Psychiatric Residential Treatment Facility Services Summary 47
Table 44. Public Health or Welfare Services Summary 48
Table 45. Public Health, Federal Services Summary 48
Table 46. Rural Health Clinic Services Summary 49
Table 47. Vision Services Summary 50
Table 48. Home and Community Based Services Waiver Summary 51
Table 49. Home and Community Based Services Waiver Expenditures History by Waiver 52
Table 50. Community Choices Waiver Summary 54

Table 51. Comprehensive Waiver Summary 55
Table 52. Supports Waiver Summary 56
Table 53. Pregnant by Choice Waiver Summary 56
Table 54. WYFI Health Exchange Outcomes Summary 58
Table 55. Administrative Transportation Summary 59
Table 56. Patient-Centered Medical Home Summary 59
Table 57. Project Out Summary 60
Table 58. Medicaid/Medicare Dual Enrollment Summary 61
Table 59. Dual-Enrolled Member Service Utilization Summary 63
Table 60. Foster Care Summary 65
Table 61. Foster Care Summary by Services - Medicaid versus State-Only 66
Table 62. Behavioral Health Services by Provider Type 67
Table 63. Waiver Services by Waiver 68
Table 64. Wyoming Medicaid Births 68
Table 65. County Summary 69
Table 66. Provider Summary by Taxonomy - SFY 2021 70
Table 67. Top 20 Provider Taxonomies by Expenditures 73
Table 68. Provider Count History by Taxonomy 73
Table 69. Reimbursement Methodology and History by Service Area 81
Table 70. Income Limits by Eligibility Category 91
Table 71. Monthly Income Standard Values by Family Size 91
Table 72. Eligibility Requirements 92
Table 73. Acronyms 99
Table 74. Medicaid Chart A Eligibility Program Codes 102
Table 75. Medicaid Chart B Eligibility Program Codes 106
Table 76. Data Parameters by Service Area 107
Table 77. Data Parameters for Subprogram and Special Populations 112

SFY 2021
AT A GLANCE

ENROLLMENT

65,250

average monthly enrollment during SFY 2021 which is an increase of 17% over SFY 2020.

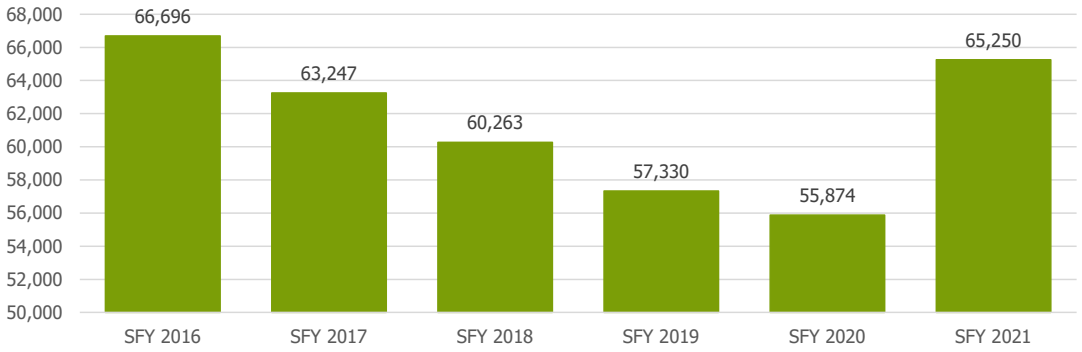


Figure 1. Enrollment History: Monthly Average

75,331

members enrolled at any point during the SFY.

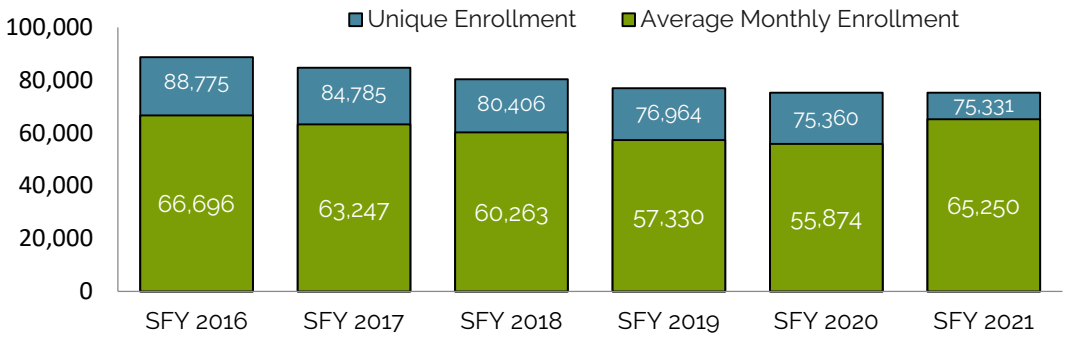


Figure 2. Enrollment History: Monthly Average and Unique Enrollment

13%

of Wyoming residents enrolled in Medicaid

62%

of members are children under age 21

45%

of members reside in Laramie, Natrona, and Fremont counties

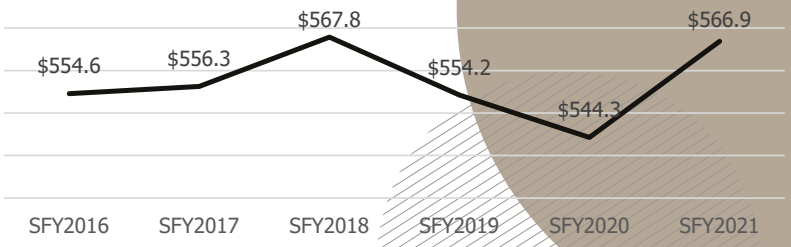
10.7

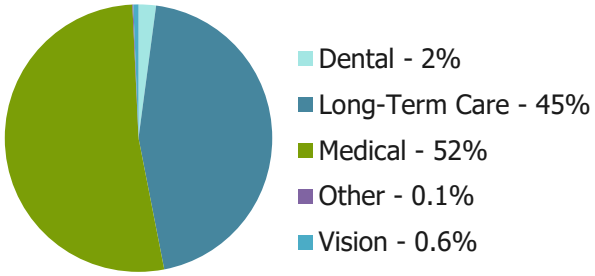
months of average enrollment per member

EXPENDITURES

$567 million

paid to 3,432 providers with over 22,544 providers actively enrolled at any point during the SFY





$660 preliminary Per Member Per Month cost

RECIPIENTS

66,708 enrolled members with claims paid

82% had a physician claim paid

51% had a prescription drug claim paid

63% had a hospital claim paid

BACKGROUND

Wyoming Medicaid is a joint federal and state government program that pays for medical care for low-income individuals and families.

Medicaid eligibility is based on residency, citizenship and identity, social security eligibility as verified by social security number, family income and, to a lesser extent, resources and/or health care needs.

The Division of Healthcare Financing (DHCF) within the Wyoming Department of Health (WDH) is the state-appointed entity for administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services.

Wyoming Medicaid serves four major eligibility populations: Children, Pregnant Women, Adults, and Aged, Blind, or Disabled. Wyoming has not extended optional eligibility to adults under 133% of Federal Poverty.

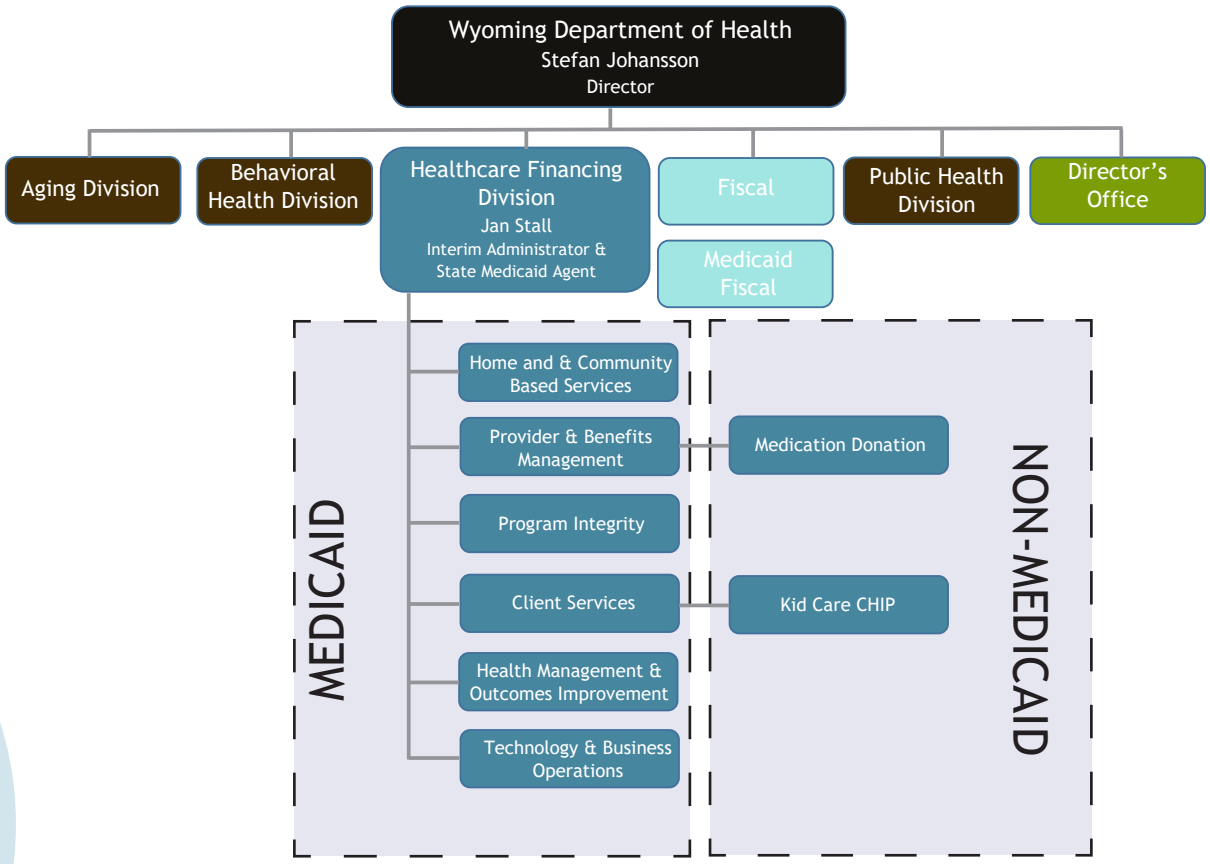


Figure 3. Wyoming Department of Health Organization Chart

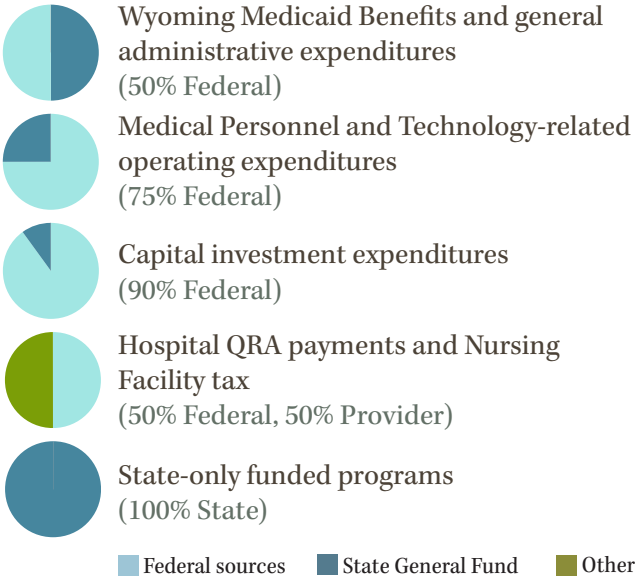
FINANCIALS & FUNDING

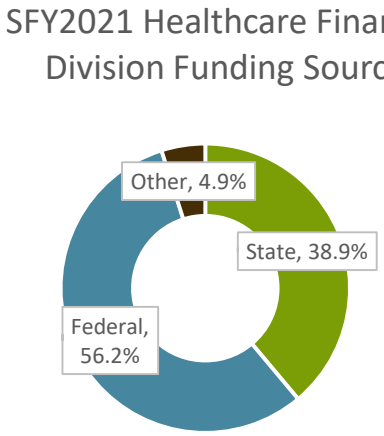
Enrolled providers have one year to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS). This Annual Report focuses on the members enrolled during SFY 2021 and claims paid during SFY 2021, regardless of when service was rendered.

Table 1. Division of Healthcare Financing Expenditures for SFY 2021

Medicaid Related Expenditures (in millions)	
Annual Report Benefit Expenditures (this report)[1]	$566.90
Medicaid Administration	$50.20
Nursing Facilities Tax Assessment	$36.40
Hospital Qualified Rate Adjustment (QRA) Payments	$32.50
Medicare Buy-In	$21.30
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	$19.60
Medicare Clawback (Part D)	$13.30
Other[2]	($5.90)
Subtotal Medicaid Expenditures	**$734.30**
Drug Rebates	($40.00)
Total Medicaid Expenditures	**$694.30**
Non-Medicaid Expenditures (in millions)	
Children's Health Insurance Program (CHIP)	$9.40
CHIP Administration	$0.30
State Only Foster Care and General Fund Foster Care (Court Orders)	$0.90
Supplemental Security Income (SSI) Payments	$1.10
Total Health Record (Health Information Exchange (HIE))	$0.20
State Only Other	$0.90
Total Non-Medicaid Expenditures	**$12.80**
Total Division of Health Care Financing	**$707.10**

1. Includes reductions in expenditures due to recoveries processed through the MMIS.
2 Adjustment to reflect timing difference related to drug rebate and claims differences between WOLFS and MMIS data.





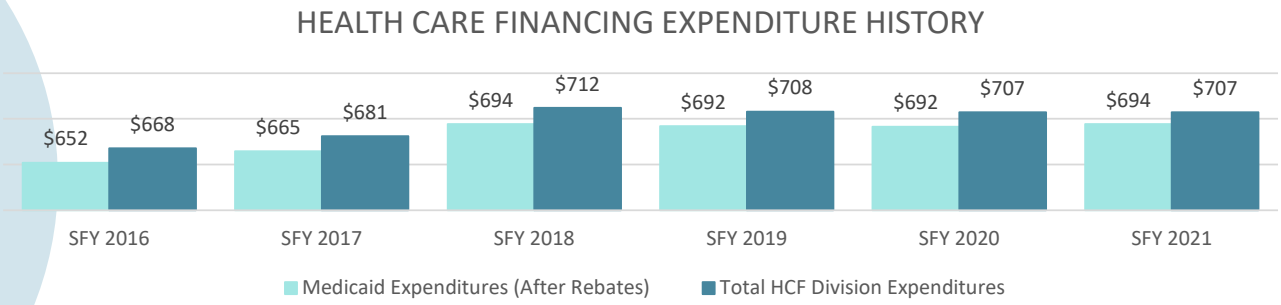


Figure 4. Health Care Financing Expenditure History

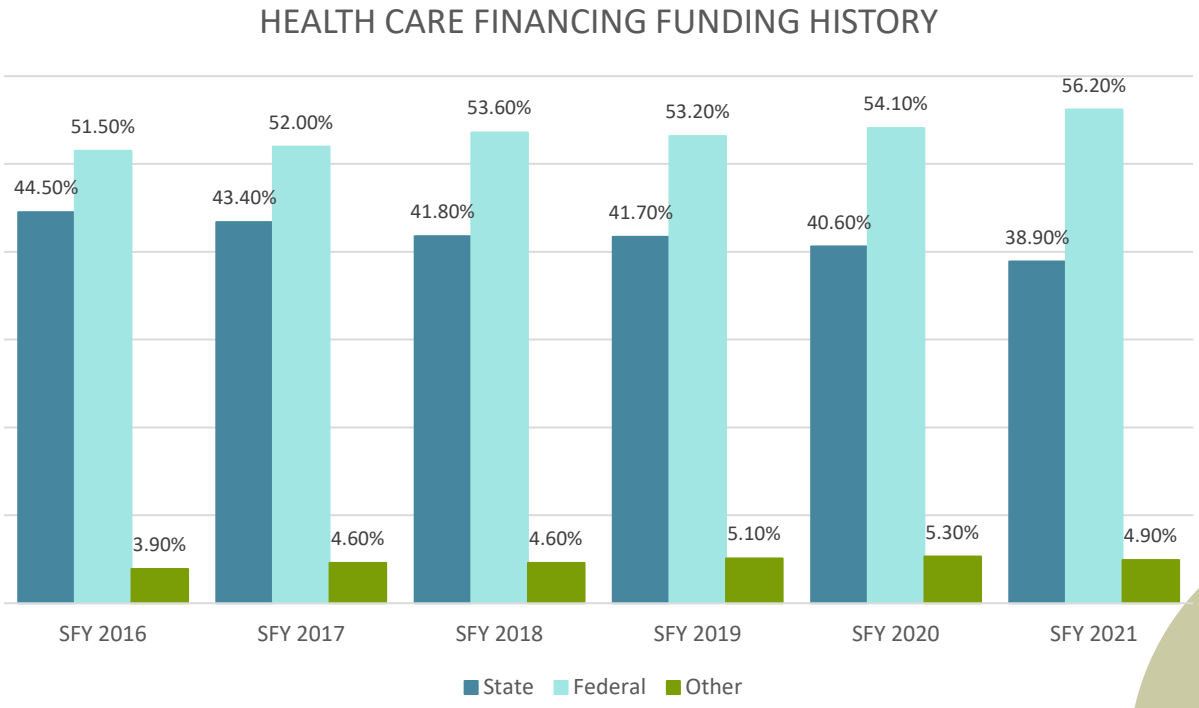


Figure 5. Health Care Financing Funding History

ADVISORY GROUPS

Table 2. Wyoming Medicaid Advisory Groups and Committees

Advisory Group	Members	Description
Dental Advisory Group (DAG)	Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Conduent.	Represents a wide range of interests, experience, dental specialties and various areas of the state, while advising Medicaid regarding administration of the dental program.
Long-Term Care Advisory Group	Nursing Home Association leadership, five nursing home providers, a home health provider, a hospice provider, an assisted living provider, a Long-Term Care waiver case manager, and an Independent Living Center representative	Focuses on issues and recommendations with institutional and community-based long-term care providers.
Medical Advisory Group (MAG)	Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners	Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues.
Pharmacy & Therapeutics Committee (P&T)	Six physicians, five pharmacists, and one allied health professional.	Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid.
Tribal Leadership Advisory Group	Tribal Business Council members, leadership and executives from tribal health clinics and Indian Health Services, long-term care providers, and representatives from all Wyoming Department of Health divisions	Focuses on new and upcoming issues within the healthcare industry, consultation with the Tribal leaders, updates from facilities, and work to develop solutions and programs to decrease barriers for this group.

PROGRAM INTEGRITY (PI) & THIRD-PARTY LIABILITY (TPL)

Funds are recovered from third party liability, estates, drugs, and credit balances.

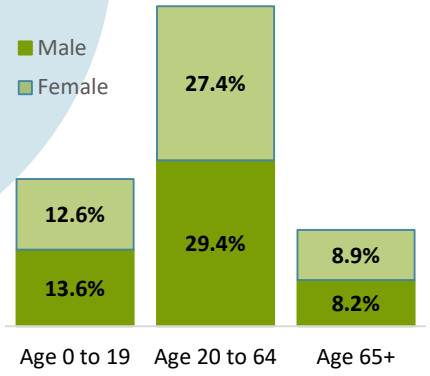
Wyoming Medicaid reviews, audits, and investigates providers for claims lacking sufficient documentation or incorrect billing.

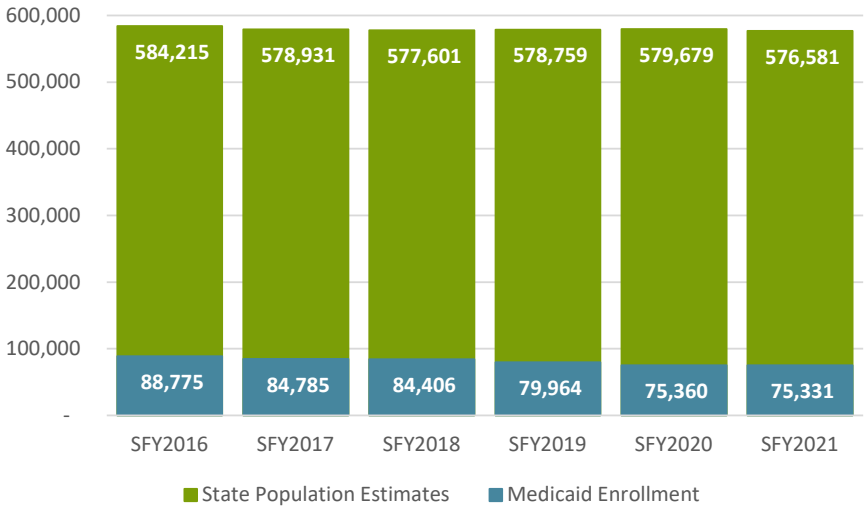
To view the most current presentations of data for these two program areas, please refer to the Program Integrity HealthStat and TPL HealthStat reports.

DEMOGRAPHICS

13%
of Wyoming residents enrolled in Medicaid

26%
of residents under age 20





State Population[3] *decreased* by

1.3%

from 2016 to 2021

Medicaid enrollment *decreased* by

17.8%

from SFY 2016 to SFY 2021

3. 2021 forecast population prepared by Wyoming Department of Administration & Information, Economic Analysis Division (http://eadiv.state.wy.us), August 2020.

ECONOMY

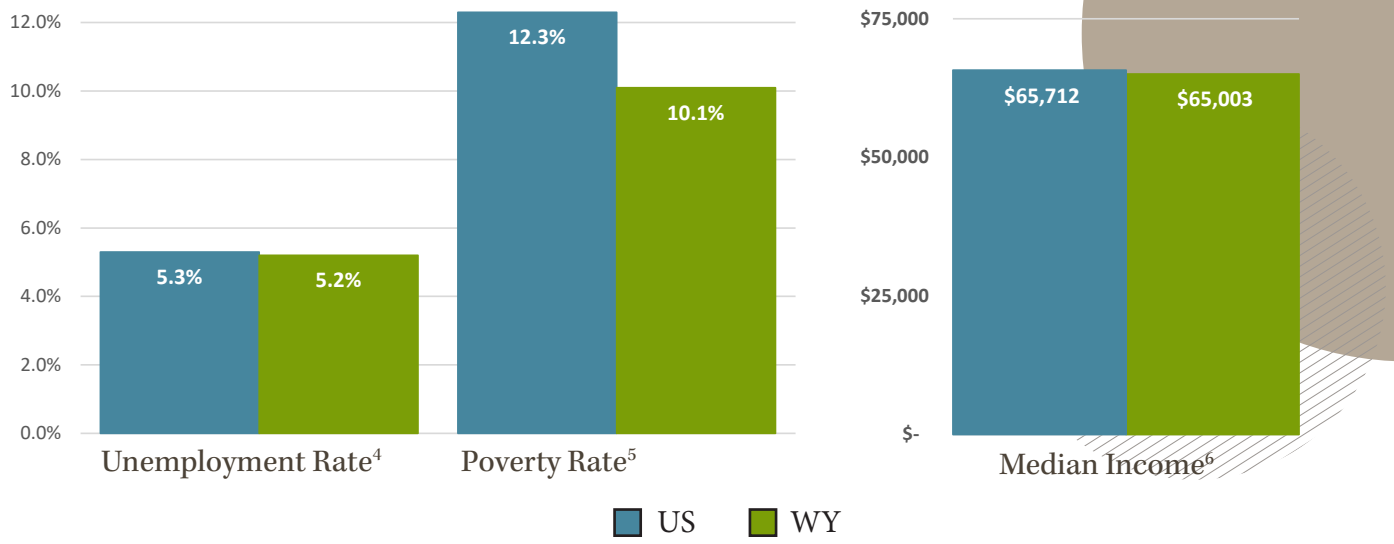


Table 3. Employment and Mean Wages by Occupation[7, 8]

	Employment Total Percent Change 2010 to 2020		Wages Total Percent Change 2010 to 2020		Mean Hourly Wages 2020	
	US	WY	US	WY	US	WY
All Occupations	9.4%	-3.0%	26.8%	23.3%	$27.07	$24.61
Healthcare Practitioners & Technical Occupations	16.8%	6.7%	20.5%	27.9%	$41.30	$41.91
Healthcare Support Workers	62.5%	48.0%	19.8%	18.7%	$15.50	$15.86

4. US Bureau of Labor Statistics. Wyoming Economy at a Glance. Unemployment Rate as of July 2021(in percent, seasonally adjusted) https://www.bls.gov/regions/mountain-plains/wyoming.htm#eag_wy.f.2 and US Bureau of Labor Statistics. Annual Unemployment Rates (2021). https://data.bls.gov/timeseries/LNU04023554&series_id=LNU04000000&series_id=LNU03023554&series_id=LNU03000000&years_option=all_years&periods_option=specific_periods&periods=Annual+Data
5. US Census Bureau. S1701: POVERTY STATUS IN THE PAST 12 MONTHS table. https://data.census.gov/cedsci/table?q=S1701: POVERTY STATUS IN THE PAST12 MONTHS&t=Income Households, Families, Individuals &tid=ACSST1Y2019.S1701
6. US Census Bureau. S1901 INCOME IN THE PAST 12 MONTHS (IN 2019 INFLATION-ADJUSTED DOLLARS) table. https://data.census.gov/cedsci/table?t=Income and Poverty&tid=ACSST1Y2019.S1901
7. Bureau of Labor Statistics, May 2020 State Occupational Employment and Wage Estimates, Wyoming. http://www.bls.gov/oes/current/oes_wy.htm
8. Bureau of Labor Statistics, May 2020 State Occupational Employment and Wage Estimates, United States. http://www.bls.gov/oes/current/oes_nat.htm

HIGHLIGHTS & INITIATIVES

PROGRAM UPDATES

- Kid-Care CHIP program transitioned from an S-CHIP to M-CHIP effective October 1, 2020, bringing the program in-house, adding program codes to the MMIS, updating the state plan, policy, and rules.
- State Supplemental payment for SSI clients reduced to $20 per client regardless of living arrangement. All clients were notified of the change 2 months prior to the change. This will reduce the general fund dollars spent on the program.
- Implemented 2.5% reimbursement rate reduction as a result of phase 2 budget reductions for developmental disabilities and prescription drugs.
- Implemented 90 day supply on generic drugs as a result of phase 2 budget reductions.
- Executed contract with Telligen for new HM/UM contract.
- Eliminated PACE program as a result of phase 2 budget reductions. All participants transitioned to other services.
- Implemented temporary rate increases for Developmental Disabilities (DD) and Community Choices Waiver (CCW) providers in response to the public health emergency (PHE).
- Implemented temporary rate increases for Nursing facilities.

POLICY

- Received CMS approval to implement the Profession Services Supplemental Payment Program.
- Received CMS approval of 5-year renewal of the Community Choices Waiver (CCW) program.
- Received Legislative approval to implement a Ground Ambulance Supplemental Payment Program and the School-Based Services Program.
- Numerous policy and reimbursement changes as a result of the public health emergency.
- Eliminated chiropractic services as a result of phase 2 budget reductions. Due to CMS requirements services not eliminated until June 1, 2021. Will still cover the service as a crossover and as an EPSDT service if found to be medically necessary.
- Unbundled the postpartum visit from the global maternity procedure codes for better tracking and ensurance of member attendance at appointments.

TECHNOLOGY

- The Wyoming Eligibility System (WES) Client Web Portal (CWP) underwent a major modernization project in October 2020. The Nevada eligibility portal code was used as the foundation for the Wyoming CWP improvements. The re-use of Nevada's code provided significant savings over the projected expenses of creating original code. The vendor replaced the existing CWP with the current Wyoming Web Portal. By adding a new CWP database and data access object layer, as well as adding new services to support the revamped CWP, WDH has implemented a robust application. The CWP now includes streamlined workflows with intuitive application processes. The improvements have increased the client use of the CWP to complete and submit applications, as well as uploading verification documents directly into the portal.

- WDH implemented a two-phased approach to send WES data to the WINGS Data Warehouse (DW) in 2020 and 2021. The purpose of this project is to enable WES users with the ability to create, edit, and manage eligibility reports by utilizing the DW Reporting tools. The current WES reporting model utilizes Pentaho reporting which is expansive due to the yearly licensing fees and fee increases. Phase 1 was completed in 2020. Phase 2 began in April 2021.
- The Customer Service Center (CSC) transitioned from the incumbent vendor in 2020 to a new vendor. The new CSC provides automation tools which should provide improvements to the client application process and eligibility determinations. The CSC maintains a local facility as well as overflow call center operations offsite. CSC's responsibilities include providing call support, disseminating program information to clients, and providing application completion assistance and status updates to clients.
- The CMS Plan of Actions and Milestones (POAM) is designed to plan for and track the remediation of deficiencies within State eligibility systems. CMS mandates annual security testing to maintain the Federal Hub connection for the WES. WDH underwent the annual POAM, created the reports and documentation, and submitted the final reports to CMS on June 30, 2021. As part of the security assessment, the MARS-E Vulnerability Scanning Control documentation was submitted to CMS for review. This review and approval will result in a three-year Authority to Connect (ATC) certificate. WES is currently operating under a one-year conditional ATC.
- Provider Enrollment Screening and Monitoring (PRESM) go-live occurred in April 2021.
- Pharmacy Benefit Management System (PBMS) implemented a data interface to the Data Warehouse to allow for enhanced reporting.

TRIBAL HEALTH

- Extended the contract with Indian Health Services (IHS) and 638 Tribal Facility until June 30, 2022. IHS will provide Medicaid eligibility functions and other activities related to the eligibility process for the Medicaid Modified Adjusted Gross Income (MAGI) group. The goal is to ensure that every effort is made to remove any internal barriers which would delay or prevent a timely eligibility determination for those individuals applying for Medicaid.

WYOMING INTEGRATED NEXT GENERATION SYSTEM

- The Wyoming Integrated Next Generation System (WINGS) is replacing the current Medicaid Management Information System (MMIS) through the procurement of separate modules over two to three years.

1 PBMS

Pharmacy Benefit Management System processes pharmacy point-of-sale claims and handles pharmacy-related prior authorizations

2 SI-ESB

System Integrator with Enterprise Service Bus connects all modules together into an enterprise system

3 DW-BI

Data Warehouse with Business Intelligence Tools serves as data storage for all other modules with tools used to compile reports and analyze the Medicaid program

4 FWA

Fraud, Waste, Abuse Analytics and Case Tracking supports the identification, investigation, and collection of fraud, waste, & abuse of Medicaid services by providers and clients

5 BMS & TPL

Benefit Management System processes Medicaid claims and manages benefit plans. Third-Party Liability ensures proper coordination exists between Medicaid and any other entity/individual with an obligation to provide financial support for Medicaid services.

6 PRESM

Provider Enrollment Screening and Monitoring supports provider enrollment through an electronic self-service solution, verifies provider licensing, and reviews/maintains all provider enrollments

7 EVV

Electronic Visit Verification measures and validates service activity for personal care and home health programs, ensuring services billed are actually rendered.

8 CCMS

Care and Case Management System develops & monitors plans of care, captures & monitors assessments, screenings, treatment plans, and authorizes services

A

Testing & Quality Assurance Quality Control Services ensures each project module functions correctly

B

Independent Verification & Validation certifies system meets all requirements and fulfills the intended purpose

Modules A & B are consulting services to support the WINGS project.

ENROLLMENT

17%

65,250
Average Monthly Enrollment

After steadily declining for five years, the average monthly enrollment in Medicaid increased by 17% during SFY 2021. As shown in Table 4, the average length of enrollment (in months) also increased by 15% after holding steady in previous years.

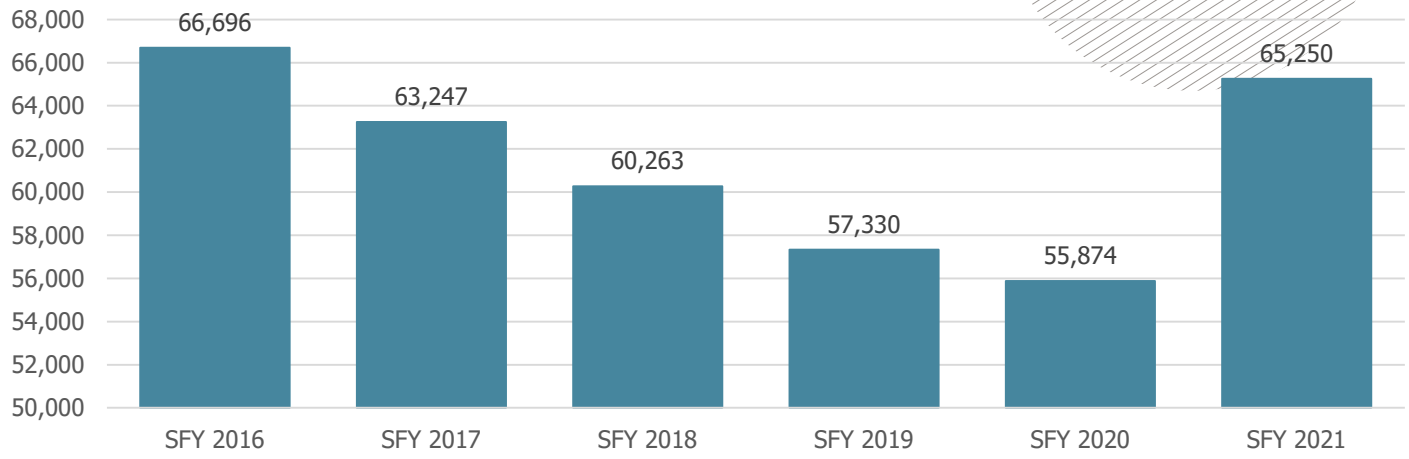


Figure 6. Enrollment History: Monthly Average

2.1%

75,331
Annual Unique Enrollment

Individuals may gain and lose eligibility throughout the SFY. As such, the unique enrollment for a complete SFY may be greater than a point-in-time unique count

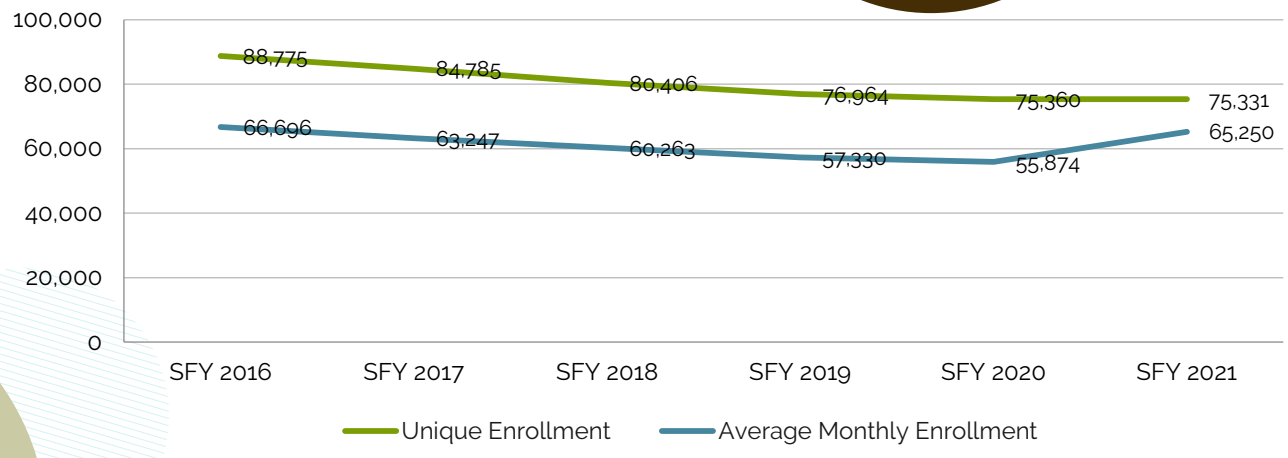


Figure 7. Enrollment History: Unique and Monthly Average

Table 4. Change in Medicaid Enrollment

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Unique Enrollment	88,775	84,785	80,604	76,964	75,360	75,331
% Change from Previous SFY	-2.5%	-4.5%	-5.2%	-4.3%	-2.1%	0.0%
Average Monthly Enrollment	66,696	63,247	60,263	57,330	55,874	65,250
% Change from Previous SFY	-10.6%	-5.2%	-4.7%	-4.9%	-2.5%	16.8%
Average Length of Enrollment (months)	9.2	9.2	9.3	9.3	9.3	10.7

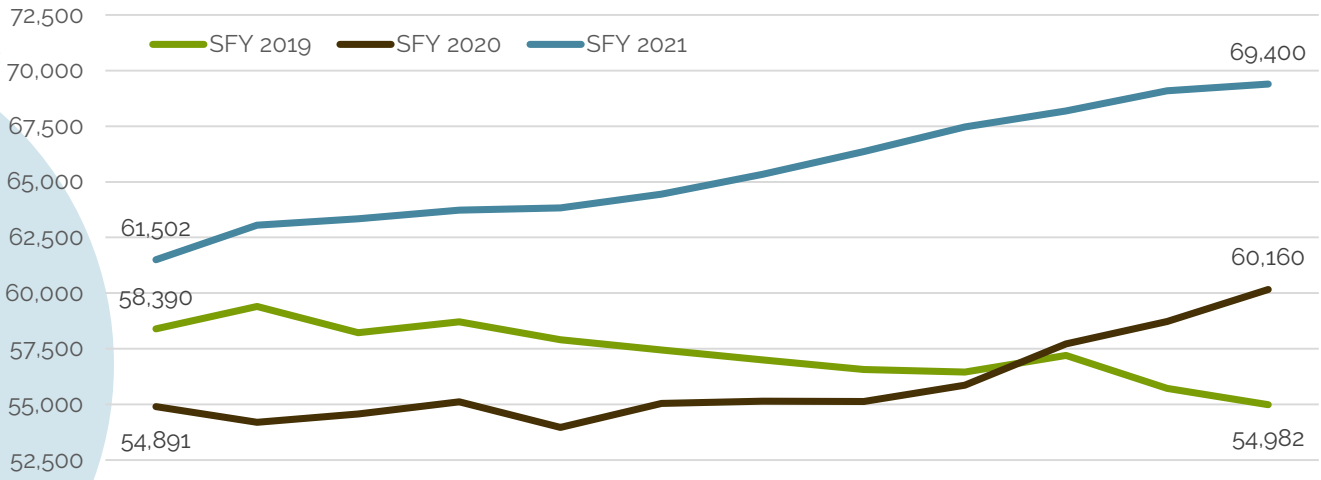


Figure 8. Monthly Medicaid Enrollment by State Fiscal Year

BY COUNTY

More than half (60%) of Medicaid members reside in 5 counties: Laramie, Natrona, Fremont, Campbell, and Sweetwater.

Table 5. Medicaid Enrollment by County

County	Enrolled Members	Percent of Total
Albany	3,278	4.4%
Big Horn	1,944	2.6%
Campbell	5,914	7.9%
Carbon	1,761	2.3%
Converse	1,772	2.4%
Crook	789	1.0%
Fremont	9,064	12.0%
Goshen	1,671	2.2%
Hot Springs	740	1.0%
Johnson	881	1.2%
Laramie	12,701	16.9%
Lincoln	1,628	2.2%
Natrona	12,100	16.1%
Niobrara	312	0.4%
Other[9]	1,777	2.4%
Park	3,403	4.5%
Platte	1,117	1.5%
Sheridan	3,610	4.8%
Sublette	668	0.9%
Sweetwater	5,501	7.3%
Teton	1,013	1.3%
Uinta	3,044	4.0%
Washakie	1,082	1.4%
Weston	764	1.0%
Total	**75,331**	

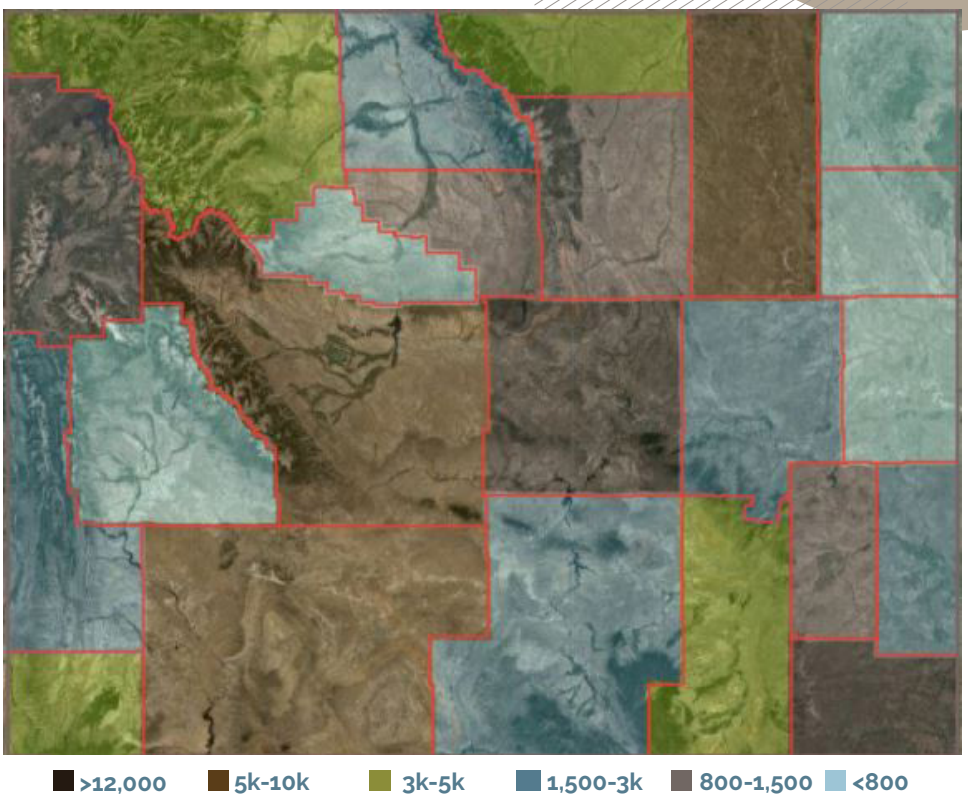


Figure 9. Wyoming County Map by Medicaid Enrollment

9. County 'Other' indicates individuals who were at one time enrolled in Medicaid, but have moved out of state. Member county of residence is based on the address on file at the time the data is extracted.

EXPENDITURES

1.9%

$566,889,365

paid to 3,432 providers with over 22,544 providers actively enrolled at any point during the SFY

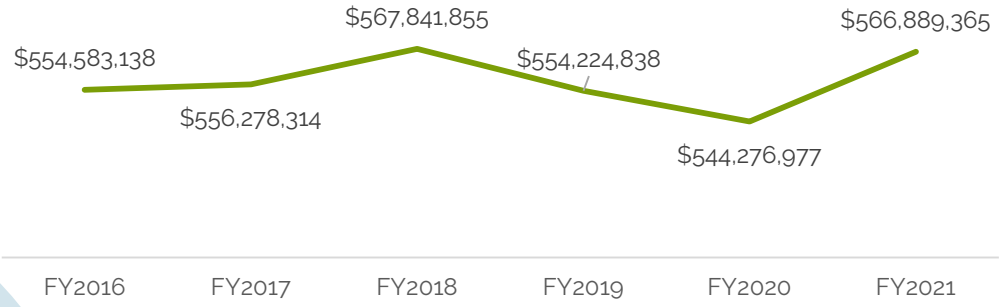


Figure 10. Expenditure History

Providers have one year to submit claims to Medicaid for reimbursement; therefore, expenditures here include services rendered in both SFY 2020 & SFY 2021

Table 6. Expenditure History by Service Type

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Medical	$303,594,435	$297,465,160	$310,261,579	$288,773,795	$270,436,091	$296,681,262
Long-Term Care	$230,992,217	$239,788,830	$241,030,693	$249,685,762	$260,153,810	$254,093,439
Dental	$15,450,029	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535
Vision	$3,652,188	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355
Other	$894,268	$1,006,132	$989,147	$995,134	$816,378	$689,774

Figure 11, below, shows how SFY 2021 paid expenditures compared to SFY 2020 for top services. Only services with over $5 million in expenditures in either SFY have been included in the figure. More detailed information on services is available in the Services section of this report. For each service area, the percentage shown is the % of Total Medicaid.

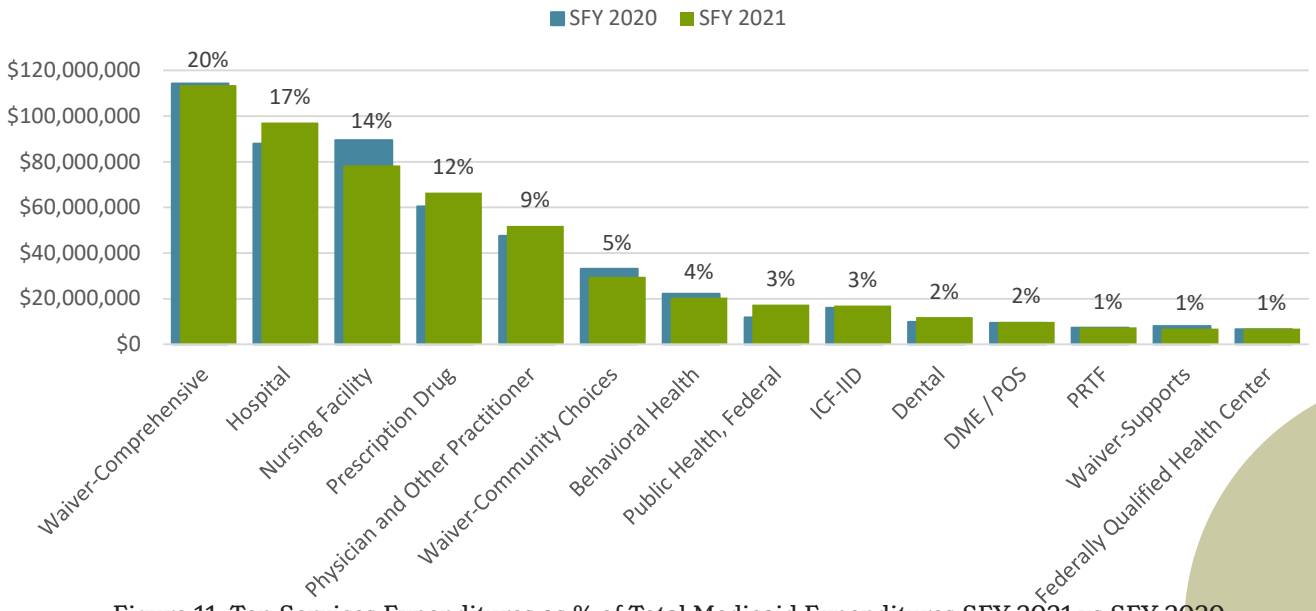


Figure 11. Top Services Expenditures as % of Total Medicaid Expenditures SFY 2021 vs SFY 2020

RECIPIENTS

2.9%

66,708

enrolled members with claims paid

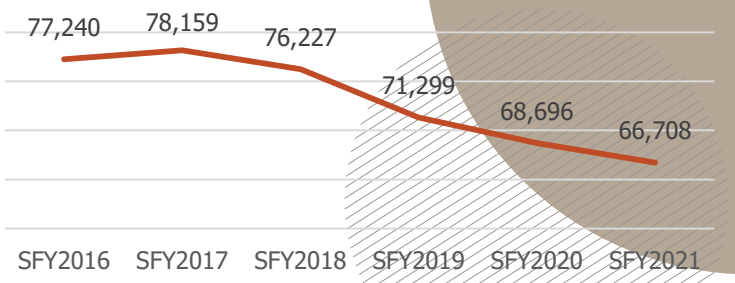


Figure 12. Recipient History

Table 7. Recipient History by Service Type

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Medical	73,337	74,599	73,266	68,197	65,448	63,016
Long-Term Care	7,368	7,605	7,684	7,711	8,193	7,671
Dental	32,046	31,483	28,789	27,525	24,732	27,609
Vision	15,369	15,921	15,821	14,790	12,680	15,016
Other	1,976	2,938	3,251	3,336	3,157	2,830

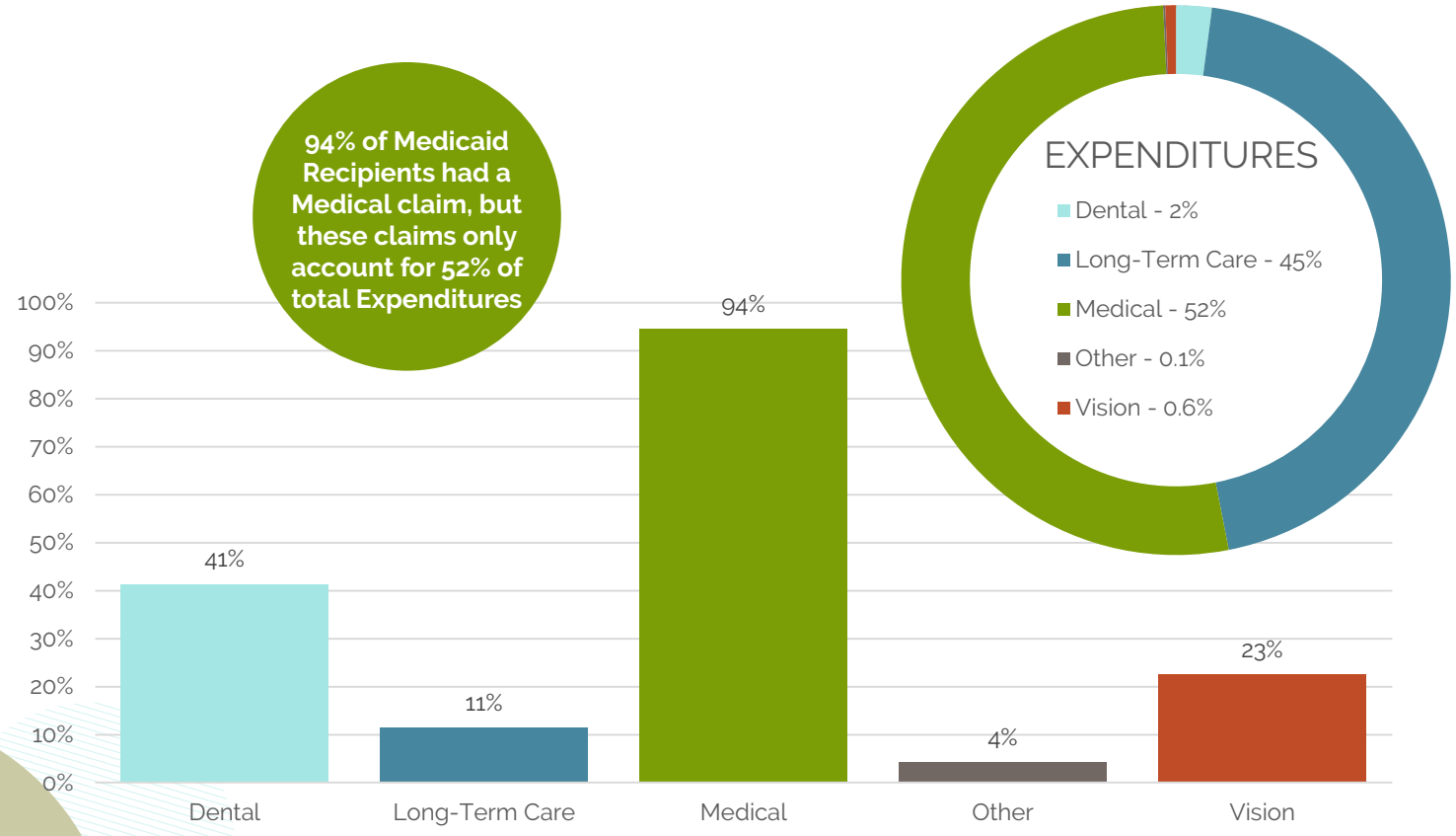


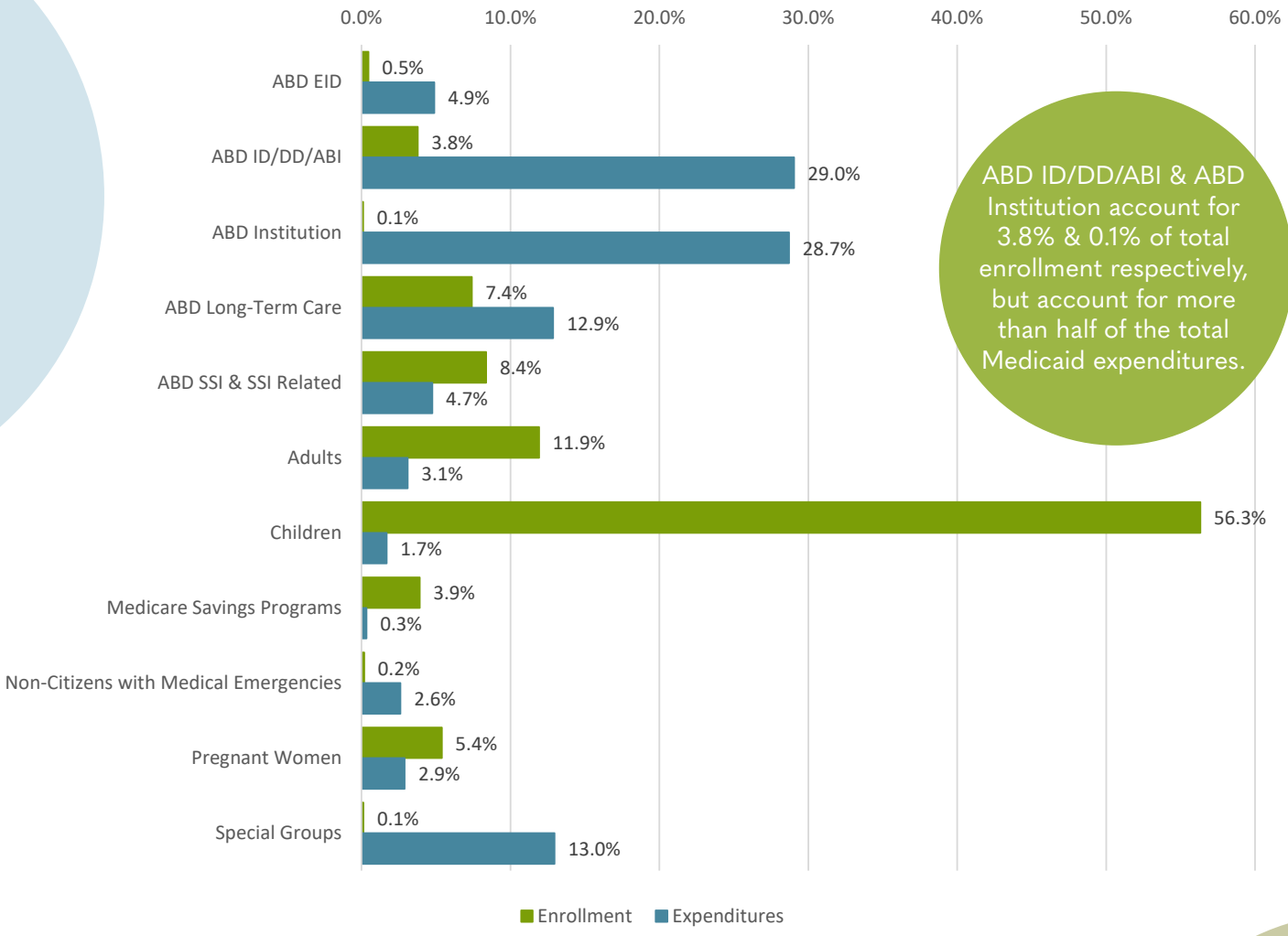
Figure 13. Recipient Utilization versus Expenditure Breakdown by Service Type

ELIGIBILITY CATEGORIES

AGED, BLIND, OR DISABLED

1. Employed Individuals with Disabilities
2. Individuals with Intellectual/ Developmental Disabilities or Acquired Brain Injury
3. Institution
4. Long-Term Care
5. Supplemental Security Income
6. Adults
7. Children
8. Medicare Savings
9. Non-Citizens with Medical Emergencies
10. Pregnant Women
11. Special Groups

Per Federal statutes, individuals qualify for Medicaid coverage based on Federal Poverty Level guidelines, Supplemental Security Income standards, or the 1996 Family Care income standard.



ABD ID/DD/ABI & ABD Institution account for 3.8% & 0.1% of total enrollment respectively, but account for more than half of the total Medicaid expenditures.

Figure 14. Enrolled Members versus Expenditures by Eligibility Category - SFY 2021

Table 8. Eligibility Category Summary

Eligibility Category	Enrolled Members	% Change from SFY 2020	Unique Recipients[10]	% Change from SFY 2020	Expenditures[11]	% Change from SFY 2020
ABD EID	331	-8	320	-19	$3,168,949	80
ABD ID/DD/ABI	2,614	0	2,633	-1	$155,360,814	2
ABD Institution	57	-14	71	-7	$4,139,118	234
ABD LTC	4,888	-4	5,160	-13	$134,892,349	-7
ABD SSI & SSI Related	6,437	-4	5,828	-4	$56,186,651	3
Adults	9,772	1	8,308	-3	$52,267,090	41
Children	44,196	0	39,258	0	$134,266,458	8
Medicare Savings Programs	4,997	-3	2,717	-8	$1,831,726	5
Non-Citizens with Medical Emergencies	177	-11	124	-13	$657,593	12
Pregnant Women	3,732	-5	3,753	-16	$22,087,873	2
Special Groups	91	-3	86	2	$2,263,994	24
Screenings	--	--	1,357	48	$524,863	31
Gross Adjustments	--	--	--	--	($758,113)	-211
Total	**75,331**	**0**	**66,708**	**-3**	**$566,889,365**	**4**

Table 9. Enrollment History by Eligibility Category

Eligibility Category	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
ABD EID	479	496	404	365	356	331	-31
ABD ID/DD/ABI	2,609	2,640	2,603	2,550	2,618	2,614	0
ABD Institution	77	80	55	46	65	57	-26
ABD LTC	4,643	4,885	5,007	5,105	5,076	4,888	-5
ABD SSI	7,039	7,117	6,609	6,737	6,661	6,437	-9
Adults	12,431	11,825	10,989	9,900	9,692	9,772	-21
Children	54,345	51,164	47,919	45,367	44,204	44,196	-19
Medicare Savings Programs	4,982	4,994	4,978	5,082	5,150	4,997	0
Non-Citizens with Medical Emergencies	432	292	195	167	158	177	-59
Pregnant Women	5,517	4,778	4,336	4,113	3,927	3,732	-32
Special Groups	250	164	121	97	88	91	-64
Total	**88,775**	**84,785**	**80,406**	**76,964**	**75,360**	**75,331**	**-15**

10. This column displays distinct count of recipients for each eligibility category, as well as the total distinct count of recipients. Summing the recipients for each eligibility category will not match the total recipients as individuals may receive services under multiple eligibility categories throughout the SFY.
11. The total gross adjustment amount for SFY2021 was negative which means that the Agency received more money than it paid out on gross adjustments.

Table 10. Expenditures History by Eligibility Category

Eligibility Category	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021[12]	5 Year % Change
ABD EID	$4,730,644	$4,491,523	$3,170,198	$2,201,872	$1,756,635	$3,168,949	-33
ABD ID/DD/ABI	$146,523,597	$145,024,485	$139,120,839	$148,210,163	$152,541,587	$155,360,814	6
ABD Institution	$3,976,596	$2,806,554	$2,489,828	$1,638,641	$1,239,234	$4,139,118	4
ABD LTC	$127,126,736	$133,820,492	$137,811,401	$136,564,759	$144,976,414	$134,892,349	6
ABD SSI	$54,218,689	$55,141,541	$57,608,075	$55,018,028	$54,412,195	56,186,651	4
Adults	$42,070,572	$40,633,756	$46,008,562	$42,819,380	$37,137,296	$52,267,090	24
Children	$144,048,715	$140,921,270	$149,233,800	$139,771,403	$124,888,851	$134,266,458	-7
Medicare Savings Programs	$4,098,086	$3,206,357	$1,654,936	$1,687,004	$1,743,350	$1,831,726	-55
Non-Citizens with Medical Emergencies	$1,212,043	$1,040,454	$713,218	$913,315	$586,871	$657,593	-46
Pregnant Women	$24,192,832	$26,264,576	$25,247,867	$22,579,721	$21,725,470	$22,087,873	-19
Special Groups	$1,871,886	$1,519,979	$1,459,944	$1,623,461	$1,826,629	$2,263,994	21
Screenings	$359,131	$249,832	$716,611	$506,557	$762,114	$524,863	46
Gross Adjustments	$153,612	$1,057,496	$2,606,576	$5,980134	$680,047	($758,113)	-594
Total	**$554,583,138**	**$556,274,739**	**$567,478,640**	**$554,032,539**	**$543,792,374**	**$566,889,365**	**2**

Table 11. Unique Recipient History by Eligibility Category[13]

Eligibility Category	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
ABD EID	472	517	455	401	382	320	-32
ABD ID/DD/ABI	2,636	2,661	2,633	2,584	2,655	2,633	0
ABD Institution	99	110	88	68	76	71	-28
ABD LTC	4,827	5,092	5,238	5,416	5,830	5,160	7
ABD SSI	6,092	6,383	6,285	6,203	6,087	5,828	-4
Adults	9,930	10,329	9,958	8,706	8,098	8,308	-16
Children	46,259	46,410	44,840	41,776	39,428	39,258	-15
Medicare Savings Programs	2,929	2,895	2,836	2,820	2,934	2,717	-7
Non-Citizens with Medical Emergencies	258	254	146	145	140	124	-52
Pregnant Women	5,491	5,346	5,149	4,389	4,342	3,753	-32
Special Groups	149	132	116	85	84	86	-42
Screenings	2,468	2,437	3,032	2,488	2,622	1,357	-45
Total	**77,240**	**78,159**	**76,227**	**71,299**	**68,696**	**66,708**	**-14**

12. The total gross adjustment amount for SFY2021 was negative which means that the Agency received more money than it paid out on gross adjustments.
13. This table displays a distinct count of recipients for each eligibility category, as well as the total distinct count of recipients. Summing the recipients for each eligibility category will not match the total recipients as individuals may receive services under multiple eligibility categories thought the SFY.

SERVICES

OVERVIEW

Table 12. Covered Services

Service	Adults	Children (Under Age 21)
Acquired Brain Injury Waiver	Optional	Optional
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Optional
Behavioral Health[14]	Optional	Mandatory (EPSDT)
Care Management Entity / Children's Mental Health Waiver	N/A	Optional
Clinic Services	Optional	Mandatory (EPSDT)
Comprehensive and Supports Waivers for Persons with ID/DD/ABI	Optional	Optional[15]
Community Choices Waiver	Optional	N/A
Dental	Optional	Mandatory (EPSDT)
Durable Medical Equipment	Optional	Mandatory (EPSDT)
End-Stage Renal Disease	Optional	Mandatory (EPSDT)
Federally Qualified Health Centers	Mandatory	Mandatory
Home Health	Mandatory	Mandatory
Hospice	Optional	Optional
Hospital	Mandatory	Mandatory
Intermediate Care Facility for Individuals with Intellectual Disabilities	Optional	Optional
Laboratory / X-Ray	Mandatory	Mandatory
Nursing Facility	Mandatory	Mandatory
Program for All-Inclusive Care of the Elderly (PACE)	Optional	N/A
Pharmacy	Optional	Mandatory (EPSDT)
Physician and Other Practitioner	Mandatory	Mandatory
Pregnant by Choice Waiver	Optional	N/A
Psychiatric Residential Treatment Facility (PRTF)	N/A	Mandatory (EPSDT)
Physical/Occupational/Speech Therapies[16]	Optional	Mandatory (EPSDT)
Public Health, Federal[17]	Mandatory	Mandatory
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Mandatory	Mandatory
Vision	Optional	Mandatory (EPSDT)

14. Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.
15. Some services in these waivers may be mandatory if the child is otherwise eligible for Medicaid without the waiver.
16. Physical/Occupational/Speech Therapies service detail is included in the Physician and Other Practitioner data in the detail section of this report.
17. Refers to Indian Health Services and Tribal 638 facilities.

Table 13. Service Utilization Summary

Service	Expenditures	% Change from SFY 2020	Recipient[18]	% Change from SFY 2020	Expenditures per Recipient	% Change from SFY 2020
Ambulance	$3,441,088	20	3,420	4	$1,006	15
Ambulatory Surgical Center	$4,183,523	32	2,714	22	$1,541	8
Behavioral Health	$20,469,939	-8	11,508	-2	$1,779	-6
Care Management Entity (CME)[19]	$3,083,353	-22	494	-47	$6,242	47
Clinic/Center	$712,388	63	920	7	$774	53
Dental	$11,898,535	20	27,609	12	$431	8
DME, Prosthetics/Orthotics/ Supplies	$9,846,339	4	8,197	6	$1,201	-2
End-Stage Renal Disease	$2,172,271	36	151	-12	$14,386	54
Federally Qualified Health Center	$6,839,456	4	7,409	0	$923	5
Home Health	$992,823	-1	243	2	$4,086	-3
Hospice	$1,297,041	4	181	-8	$7,166	12
Hospital Total	$87,874,110	11	41,865	-7	$2,381	21
Inpatient	$71,378,127.	12	8,312	-23	$8,587	45
Outpatient	$26,453,299	13	33,134	-2	$798	16
Other Hospital	$(713,623)	-185	419	0	$(1,703)	-185
Intermediate Care Facility-IID	$17,024,561	6	53	-9	$321,218	16
Laboratory	$797,433	36	7,159	20	$111	13
Nursing Facility	$78,447,126	-12	2,317	-18	$33,857	7
Other	$689,774	-16	2,830	-10	$244	-6
PACE[20]	$2,152985	-40	143	-23	$15,056	-22
Physician & Other Practitioner	$51,893,246	9	54,573	-2	$951	11
Prescription Drug	$66,453,925	10	34,291	-7	$1,938	19
PRTF	$7,517,488	2	202	-9	$37,215	12
Public Health or Welfare	$694,400	-22	6,242	-16	$111	-7
Public Health, Federal	$17,453,190	47	3,934	6	$4,436	38
Rural Health Clinic	$2,708,379	14	5,967	7	$454	6
Vision	$3,526,355	18	15,016	18	$235	0
Waiver Total	$150,076,885	4	5,524	1	$28,146	2
Community Choices	$29,661,574	12	2,958	3	$11,206	9
Comprehensive	$113,532,461	1	1,892	-2	$60,398	3
Supports	6,882,850	17	674	5	$11,954	12
Total	**$566,889,365**	**4**	**68,708**	**-3**	**$8,498**	**7**

18. This table displays a unique count of recipients for each service area, as well as the total unique count of recipients for all of Medicaid. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.
19. The Care Management Entity service includes $60,836 in expenditures paid for 12 children while enrolled in non-Medicaid state-funded institutional foster care.
20. The PACE program was discontinued in January 2021.

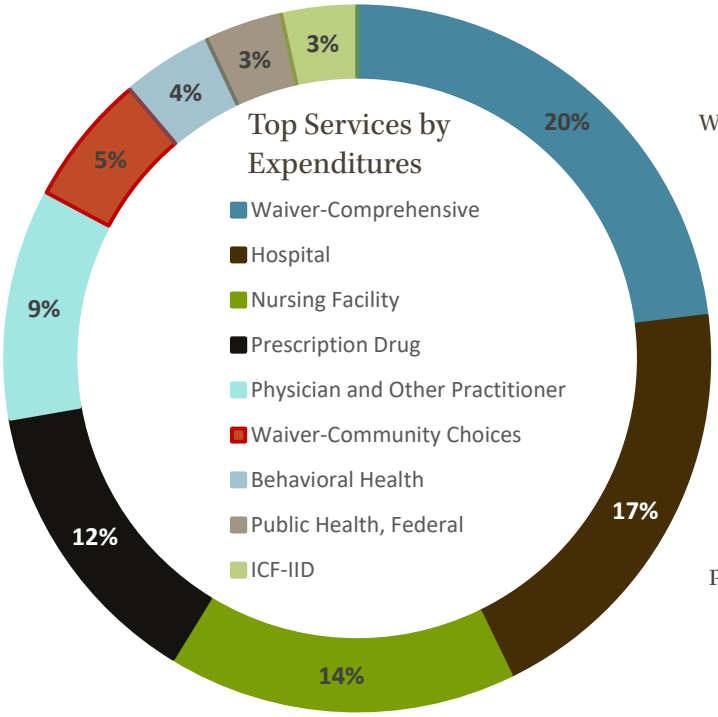


Figure 15. SFY 2021 Top Services by Expenditures[21]

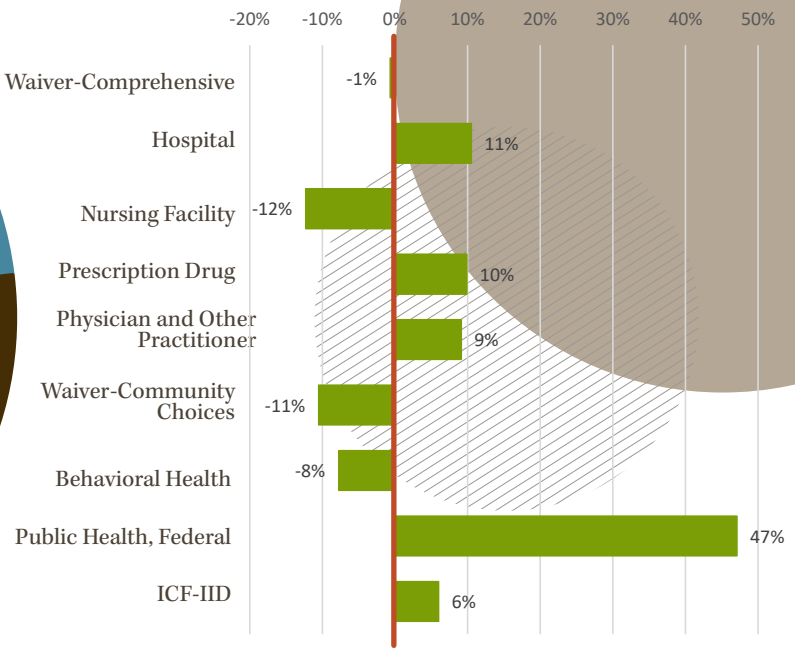


Figure 16. One-Year Change in Expenditures for Top Services

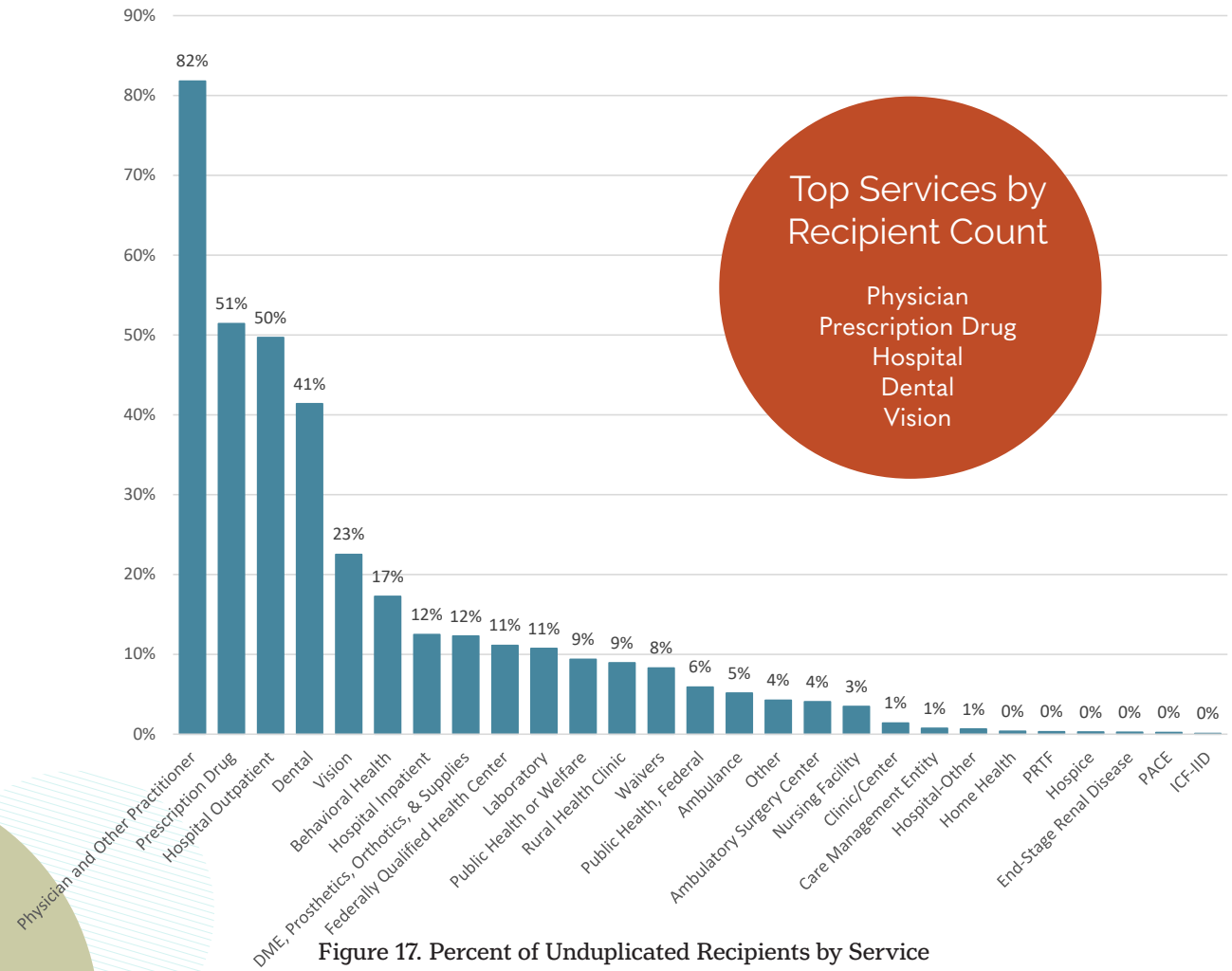


Figure 17. Percent of Unduplicated Recipients by Service

21. ICF-IID: Intermediate Care Facility for Individuals with Intellectual Disabilities

Table 14. Expenditure History by Service

Service	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Ambulance	$3,571,623	$3,847,375	$2,381,969	$3,543,958	$2,869,734	$3,441,088	-4
Ambulatory Surgical Center	$5,953,159	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	-30
Behavioral Health	$34,964,154	$30,797,112	$26,370,315	$23,634,879	$21,705,529	$20,469,939	-41
Care Management Entity[22]	$5,021,978	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353	-39
Clinic/Center	$1,361,953	$1,327,800	$972,701	$815,334	$435,776	$712,388	-48
Dental	$15,450,029	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535	-23
DME, Prosthetics/ Orthotics/Supplies	$8,200,062	$9,029,583	$8,390,660	$9,013,400	$9,490,750	$9,846,339	20
End-Stage Renal Disease	$948,612	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	129
Federally Qualified Health Center	$3,689,548	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	85
Home Health	$9,467,835	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	-90
Hospice	$1,014,959	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	28
Hospital Total	$107,692,150	$98,467,703	$97,086,021	$97,635,206	$87,874,110	$97,117,803	-10
Inpatient	$78,575,068	$71,022,272	$72,073,654	$71,923,532	$63,651,012	$71,378,127	-9
Outpatient	$28,975,050	$27,373,462	$25,021,868	$25,558,107	$23,383,212	$26,453,299	-9
Other Hospital	$142,031	$71,969	-$9,501	$153,567	$839,885	$(713,623)	-602
Intermediate Care Facility-IID	$18,193,221	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	-6
Laboratory	$1,536,310	$844,218	$1,020,356	$719,701	$585,977	$797,433	-48
Nursing Facility	$82,445,811	$87,001,112	$87,304,589	$84,440,433	$89,426,962	$78,447,126	-5
Other	$894,389	$1,006,132	$989,147	$995,134	$816,378	$689,774	-23
PACE	$2,934,877	$3,520,283	$3,471,255	$3,693,978	$3,586,650	$2,152,985	-27
Physician & Other Practitioner	$58,278,406	$60,013,763	$55,788,175	$50,649,977	$47,546,368	$51,893,246	-11
Prescription Drug	$48,597,364	$50,300,175	$57,642,641	$61,612,808	$60,473,215	$66,453,925	37
PRTF	$11,797,657	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	-27
Public Health or Welfare	$1,072,715	$912,444	$881,179	$917,179	$894,081	$694,400	-36
Public Health, Federal	$8,479,944	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	-35
Rural Health Clinic	$1,413,842	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	106
Vision	$3,652,188	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355	92
Waiver Total	$117,950,352	$120,465,765	$132,243,321	$148,078,894	$150,076,885	$155,475,943	32
Acquired Brain Injury	$6,748,171	$6,960,893	$4,948,202	$15,008	--	--	--
Adult ID/DD	$1,674	$1,565	--	--	--	--	--
Child ID/DD	$179,173	--	--	--	--		--
Children's Mental Health	$61,981	--	--	--	--	--	--
Community Choices	$19,801,298	$20,597,605	$26,930,997	$28,957,689	$29,661,574	33,146,032.62	67
Comprehensive	$88,377,607	$88,527,446	$94,568,471	$112,673,503	$113,532,461	114,273,064.64	29
Supports	$2,780,450	$4,378,255	$5,795,651	$6,432,694	$6,882,850	8,056,845.89	190
Total	**$554,583,138**	**$556,274,739**	**$567,478,640**	**$554,032,539**	**$543,792,374**	**$566,889,365**	**2**

22. The Care Management Entity service includes expenditures paid for non-Medicaid children in state-funded institutional foster care.

Table 15. Expenditure History by Other Services[23]

Service	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Case Management	$254,740	$409,938	$295,274	$188,388	$24,621	$5,940	-98
Chiropractor	$99,664	$280,207	$347,441	$406,862	$368,608	$337,670	239
Clinic/Center, Ambulatory Family Planning Facility	$55,497	$62,853	$51,449	$51,977	$48,668	$41,326	-26
Clinic/Center, Radiology, Mobile	$7	--	--	--	$0	--	--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$146,226	$84,406	$29,156	$26,024	$22,394	$26,454	-82
Day Training, Developmentally Disabled Services	$52,304	$58,362	$49,662	$65,931	$109,037	$34,335	-34
Dietitian, Registered	--	$391	$1,803	$617	$697	$385	--
Interpreter	$47,205	$32,056	$22,119	$5,799	$9,096	$17,094	-64
Lodging	--	$53,950	$85,915	$127,715	$108,735	$105,625	--
Midwife	--	--	--		$14,782	$36,514	--
Private Vehicle	--	$7,329	$11,145	$18,455	$12,973	$8,702	--
Residential Treatment Facility, Emotionally Disturbed Children	$237,904	--	--	--	--	--	--
Specialist	--	--	$61,574	$58,231	$60,043	$56,864	--
Supports Brokerage	-$80	$0	$0	--	--		--
Taxi	--	$16,674	$33,435	$45,135	$36,725	$ 18,86	--
Technician, Pathology, Phlebotomy	$575	--	--	--	--	--	--
Unclassified	$346	-$34	$174	--	--	--	--
Total	**$894,389**	**$1,006,132**	**$989,147**	**$995,134**	**$816,378**	**$689,7734**	**26**

23. This table shows services that fall outside the criteria ranges used to define other service areas for this report, as defined by the pay-to-provider taxonomy.

Table 16. Recipient Count History by Service[24]

Service	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Ambulance	3,356	3,664	3,200	3,528	3,276	3,420	2
Ambulatory Surgical Center	3,431	3,343	3,202	2,710	2,216	2,714	-21
Behavioral Health	12,813	13,317	12,949	12,448	11,395	11,508	-10
Care Management Entity[25]	342	485	606	897	927	494	44
Clinic/Center	1,533	1,434	1,256	1,142	860	920	-40
Dental	32,046	31,483	28,789	27,525	24,733	27,609	-14
DME, Prosthetics/Orthotics/ Supplies	7,158	7,476	7,367	7,497	7,712	8,197	15
End-Stage Renal Disease	131	149	158	150	171	151	15
Federally Qualified Health Center	6,450	7,052	8,927	6,340	7,422	7,409	15
Home Health	738	720	496	163	239	243	-67
Hospice	202	228	232	245	196	181	-10
Hospital Total	41,176	39,960	39,730	37,774	36,741	45,110	-15
Inpatient	10,203	10,262	9,281	8,810	10,736	8,312	-19
Outpatient	38,990	37,523	37,875	35,935	33,955	33,134	-15
Other Hospital	178	256	544	419	420	419	135
Intermediate Care Facility-IID	71	67	61	54	58	53	-25
Laboratory	9,601	8,045	8,334	6,790	5,967	7,159	-25
Nursing Facility	2,432	2,578	2,569	2,516	2,826	2,317	-5
Other	1,977	2,938	3,251	3,336	3,157	2,830	43
PACE	119	143	178	163	186	143	20
Physician & Other Practitioner	61,722	64,072	62,680	58,646	55,470	54,573	-12
Prescription Drug	44,522	43,599	42,669	40,801	36,997	34,291	-23
PRTF	301	299	298	309	221	202	-33
Public Health or Welfare	8,222	7,928	8,072	7,590	7,465	6,242	-24
Public Health, Federal	3,433	3,531	4,138	4,135	3,696	3,934	15
Rural Health Clinic	3,835	4,577	5,541	6,113	5,562	5,967	56
Vision	15,369	15,921	15,821	14,790	12,680	15,016	-2
Waiver Total	5,070	5,286	5,479	5,630	5,891	4,646	19
Acquired Brain Injury	163	162	144	19	--	--	--
Adult ID/DD	2	1	--	--	--	--	--
Child ID/DD	148	--	--	--	--	--	--
Children's Mental Health	40	--	--	--	--	--	--
Community Choices	2,295	2,414	2,622	2,828	2,875	2,958	29
Comprehensive	1,927	1,863	1,962	1,959	1,932	1,892	-2
Supports	424	540	565	568	644	674	59
Total	**77,246**	**78,165**	**76,255**	**71,300**	**68,673**	**66,708**	**-14**

24. This table displays a unique count of recipients for each service area, as well as the total unique count of recipients for all of Medicaid. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.
25. The Care Management Entity service recipient count includes non-Medicaid children in state-funded institutional foster care.

DETAILS

This section provides a detailed view of the services presented in the overview. Services are defined by the taxonomy of the provider paid for the service.

AMBULANCE

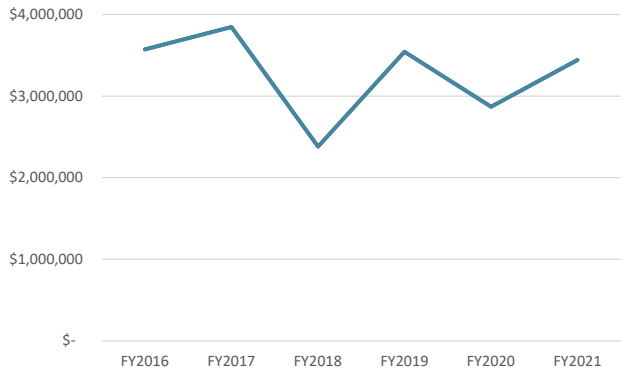
Emergency ground and air transportation and limited non-emergent ground transportation

EXPENDITURES

19.9%

$3,441,088

1% of Medicaid Expenditures



RECIPIENTS

4.4%

3,420

5% of Medicaid Recipients

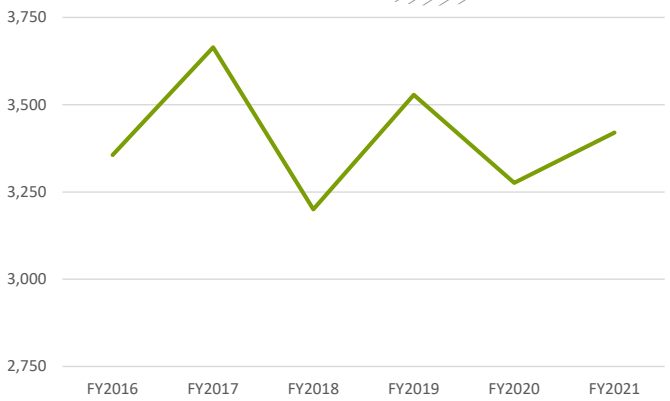


Table 17. Ambulance Services Summary[26]

Total Ambulance Services	SFY 2016	SFY 2076	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$3,571,623	$3,847,375	$2,381,969	$3,543,958	$2,869,734	$3,441,088	-4
Recipients	3,356	3,664	3,200	3,528	3,276	3,420	2
Expenditures per Recipient	$1,064	$1,050	$744	$1,005	$876	$1,006	-5
Air Ambulance Services							
Expenditures	$2,310,149	$2,444,615	$1,342,922	$2,406,019	$1,823,177	$2,340,683	1
Recipients	490	518	370	565	460	588	20
Expenditures per Recipient	$4,715	$4,719	$3,630	$4,258	$3,963	$3,981	-16
Ground Ambulance Services							
Expenditures	$1,250,134	$1,402,066	$1,033,707	$1,095,716	$1,079,870	$1,097,133	-12
Recipients	3,174	3,483	3,068	3,300	3,092	3,174	0
Expenditures per Recipient	$394	$403	$337	$332	$349	$346	-12

26. Total Ambulance service expenditures include gross adjustments which are not included in the Air and Ground breakdowns; therefore, these will not match the total expenditures when summed.

AMBULATORY SURGERY CENTER

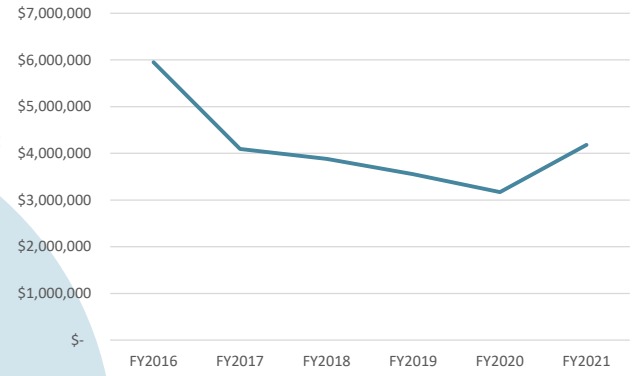
Surgical procedures that do not require overnight inpatient hospital care. Encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. ASC services may also be provided in an outpatient hospital setting.

EXPENDITURES

32.0%

$4,183,523

1% of Medicaid Expenditures



RECIPIENTS

22.5%

2,714

4% of Medicaid Recipients

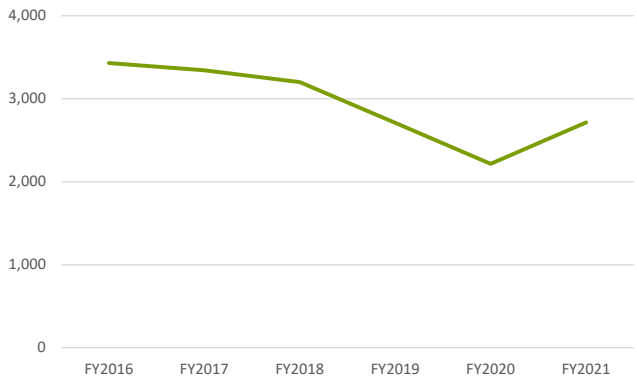


Table 18. Ambulatory Surgery Center Services Summary

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	5 Year % Change
Expenditures	$5,953,159	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	-30
Recipients	3,431	3,343	3,202	2,710	2,216	2,714	-21
Expenditures per Recipient	$1,735	$1,225	$1,212	$1,312	$1,431	$1,541	-11

BEHAVIORAL HEALTH

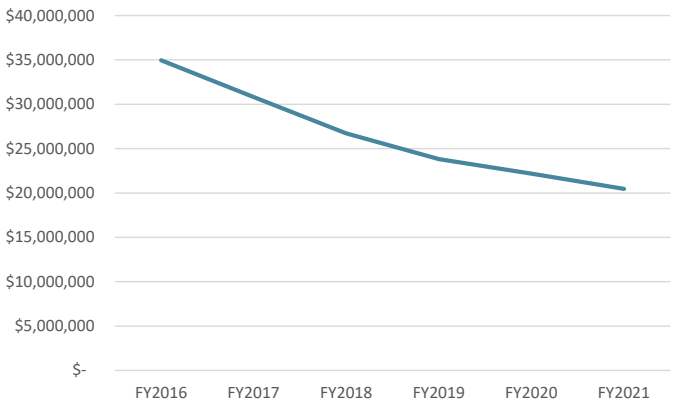
Outpatient and community-based behavioral health services for Wyoming Medicaid clients who are experiencing mental health and/or substance use symptoms.

EXPENDITURES

7.7%

$20,469,939

4% of Medicaid Expenditures

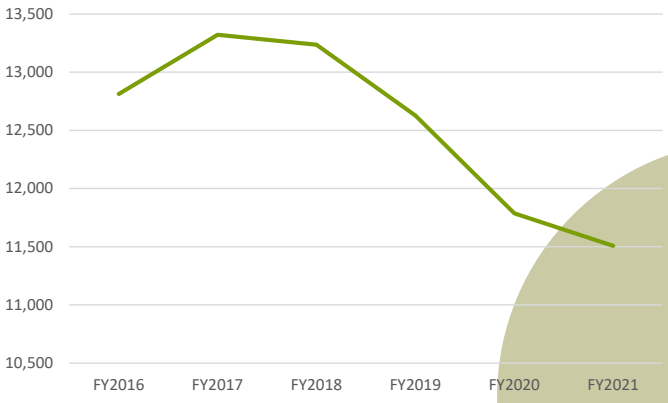


RECIPIENTS

2.4%

11,508

17% of Medicaid Recipients



Non-behavioral health providers may provide behavioral health services. These are not included in the summary figures on the previous page.

These expenditures paid to non-behavioral health taxonomies increased by 33% in SFY 2021 from the previous SFY, while the number of recipients receiving services from these providers increased by 10%.

More details are provided in Table 20.

Table 19. Behavioral Health Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Behavioral Health Services							
Expenditures	$34,964,154	$30,800,687	$26,723,530	$23,818,379	$22,188,174	$20,469,939	-41
Recipients	12,813	13,322	13,236	12,626	11,787	11,508	-10
Expenditures per Recipient	$2,729	$2,312	$2,019	$1,886	$1,882	$1,779	-35
Non-Behavioral Health Provider Services[22]							
Expenditures	$2,561,964	$1,914,675	$3,299,796	$3,589,347	$5,766,724	$7,681,583	184
Recipients	4,452	4,841	5,347	5,487	6,593	7,236	65
Expenditures per Recipient	$575	$396	$617	$654	$875	$1062	73

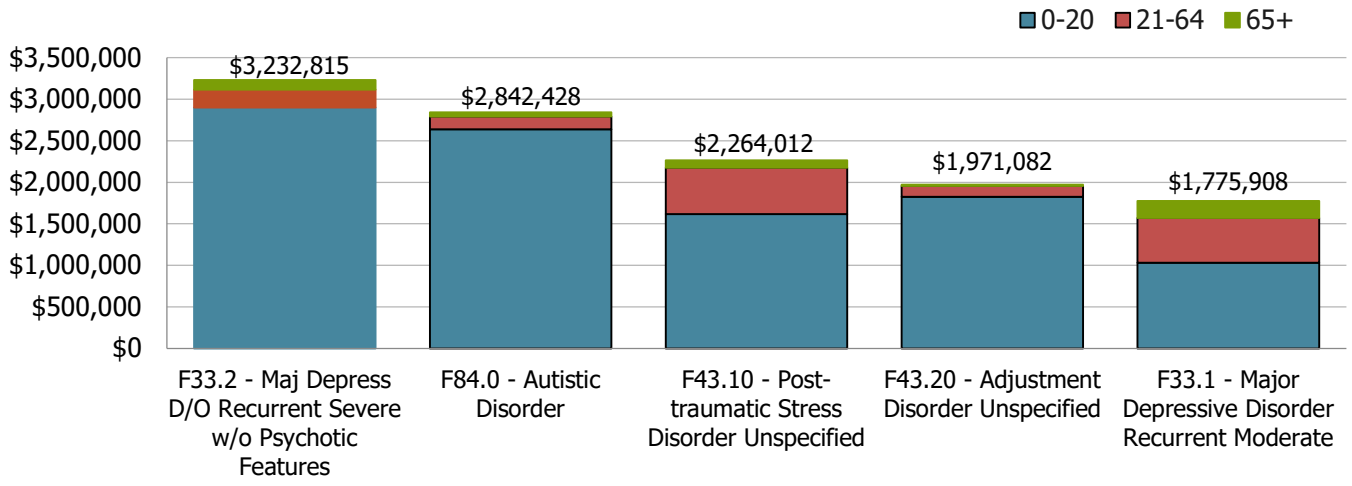


Figure 18. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Dementia and Alzheimers)

Table 20. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types[27]

Diagnosis Code and Description	Age 0-20	Age 21-64	Age 65+	Total
F33.2 - Maj Depress D/O Recurrent Severe w/o Psychotic Features	$2,901,009	$214,278	$117,528	$3,232,815
F84.0 - Autistic Disorder	$2,639,123	$153,251	$50,054	$2,842,428
F43.10 - Post-traumatic Stress Disorder Unspecified	$1,615,614	$560,487	$87,911	$2,264,012
F43.20 - Adjustment Disorder Unspecified	$1,825,816	$129,632	$15,635	$1,971,082
F33.1 - Major Depressive Disorder Recurrent Moderate	$1,030,736	$539,797	$205,374	$1,775,908
Total	**$10,012,298**	**$1,597,445**	**$476,502**	**$12,086,245**

Medicaid provides a wide range of covered medical, behavioral and long-term care services. Some recipients receive full benefits while others receive partial or limited benefits. Medicaid covers mandatory services as required by the federal government and optional services authorized by the Wyoming Legislature. Rate information and reimbursement methodology and history are available in Appendix B.

CARE MANAGEMENT ENTITY

Provides intensive care coordination to children and youth with complex behavioral health conditions and their families, using a High Fidelity Wrap-around model to support their success in their homes, schools, and communities. Started in SFY 2016.

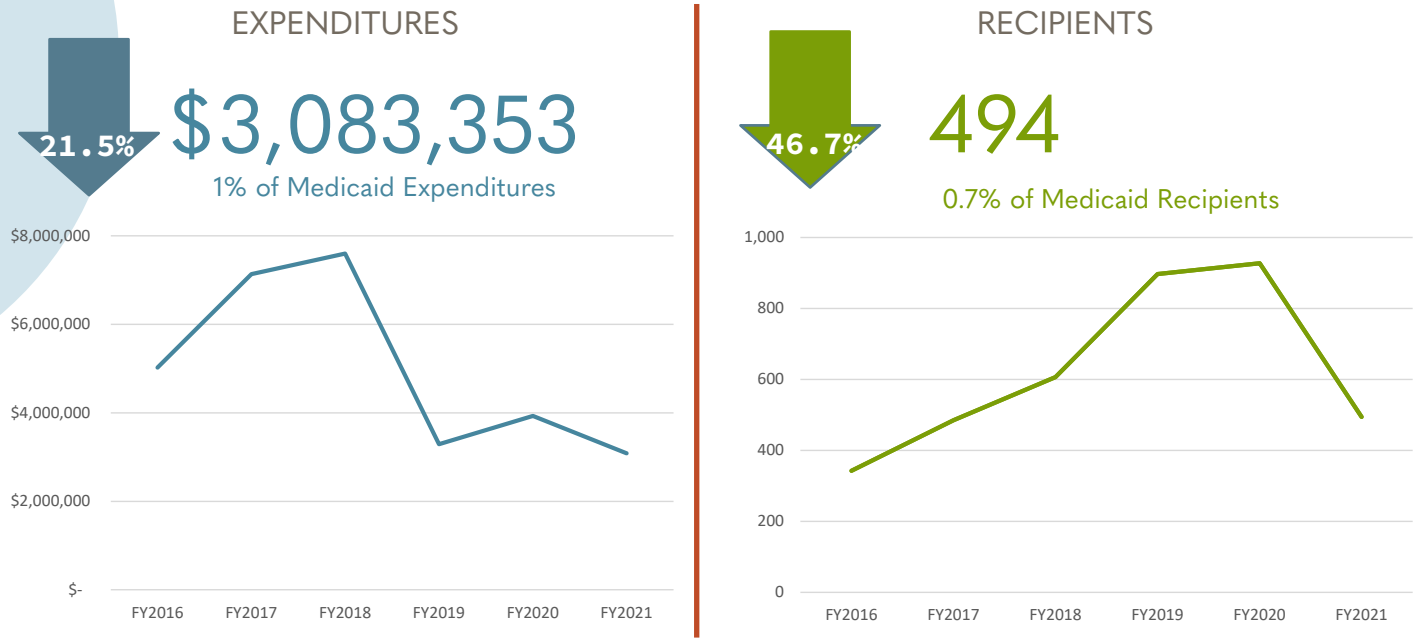


Table 21. Care Management Entity Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY2021
Expenditures	$5,021,978	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353
Recipients	342	485	606	897	927	494
Expenditures per Recipient	$14,684	$14,712	$12,540	$3,668	$4,238	$6,242

27. See Appendix B for additional information regarding the types of providers who provide Behavioral Health services.

CLINIC / CENTER

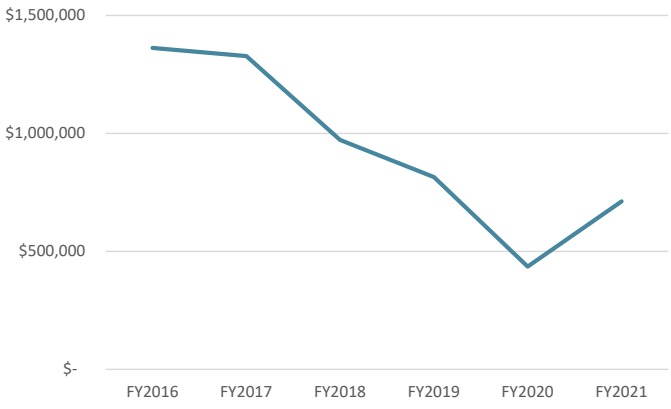
Services for clients with developmental disabilities who qualify for programs, training, care, treatment, and supervision in a structured setting, provided by state or privately funded facilities. Services include diagnostic evaluations and assessments, physical, occupational, and speech therapies, and mental health services for clients age 5 and younger.

EXPENDITURES

63.5%

$712,388

0.1% of Medicaid Expenditures



RECIPIENTS

7.0%

920

1% of Medicaid Recipients

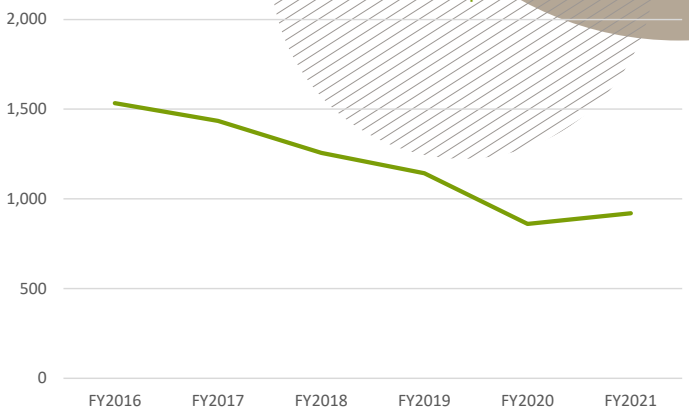


Table 22. Clinic/Center Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$1,361,953	$1,327,800	$972,701	$815,334	$435,776	$712,388	63.5
Recipients	1,533	1,434	1,256	1,142	860	920	7
Expenditures per Recipient	$888	$926	$774	$714	$507	$774	53

DENTAL

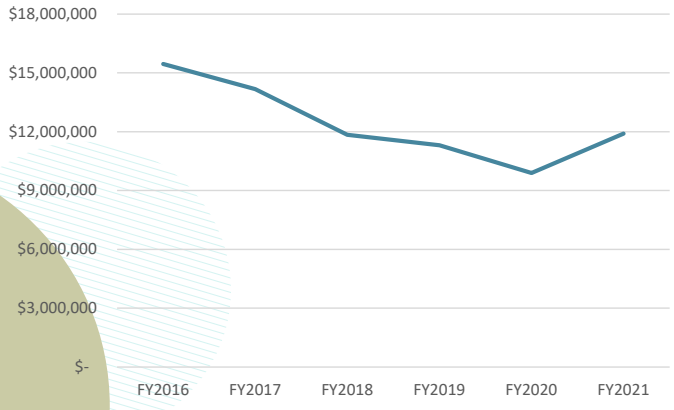
Dental services are covered based on enrolled members' age, with the goal of ensuring access to dental care so recipients may avoid emergency dental situations by receiving preventive and routine dental services for overall oral health.

EXPENDITURES

20.3%

$11,898,535

2% of Medicaid Expenditures



RECIPIENTS

11.6%

27,609

41% of Medicaid Recipients

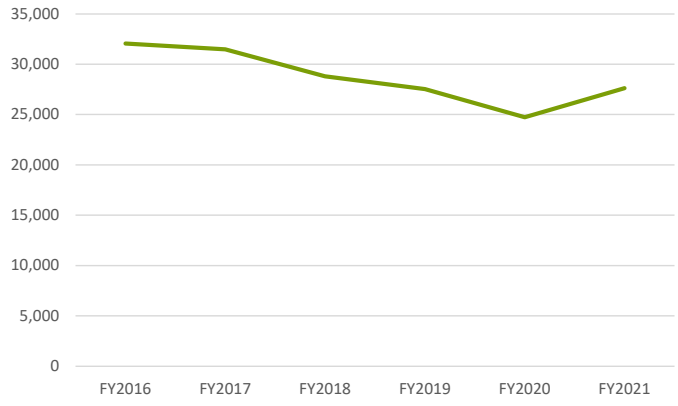
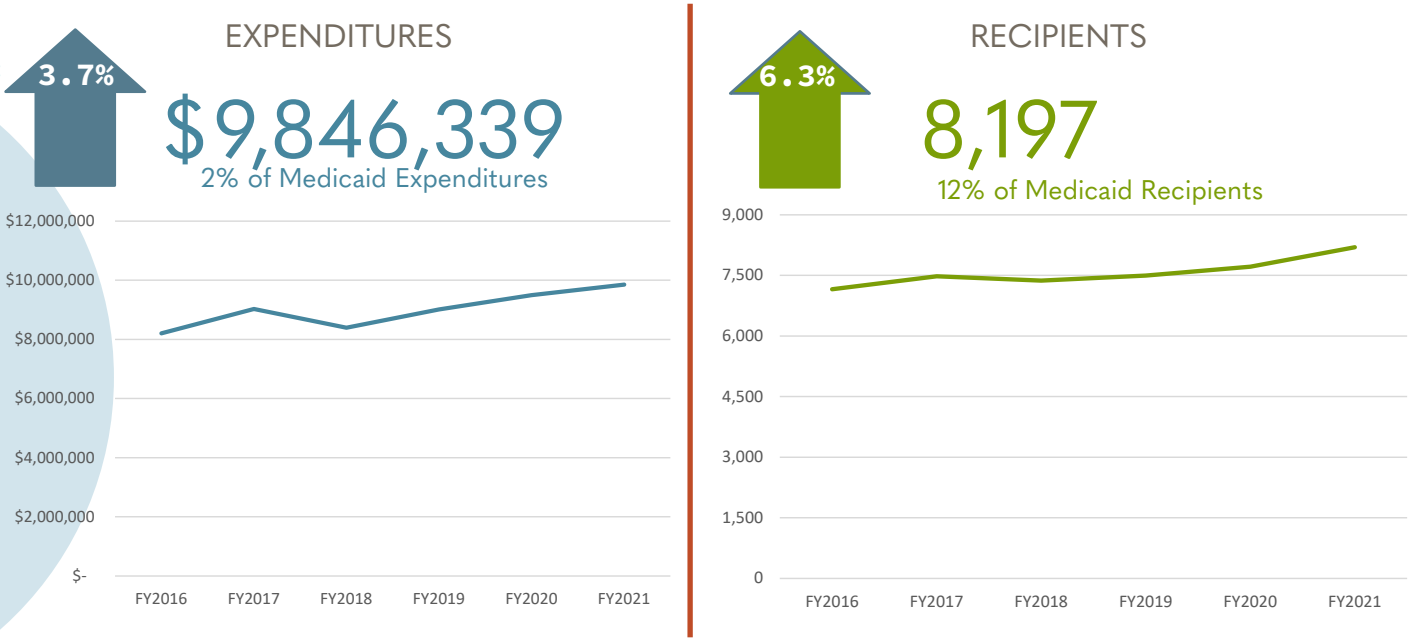


Table 23. Dental Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$15,450,029	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535	20
Recipients	32,046	31,483	28,789	27,525	24,733	27,609	12
Expenditures per Recipient	$482	$450	$412	$411	$400	$431	8

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, & SUPPLIES

Services are covered when ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to a functional level.



Medicaid covers rental of the durable medical equipment (DME), and applies rental payments toward the purchase of the item when the cost of renting equals the cost of purchase, or at the end of 10 months of rental. Medicaid automatically purchases low-cost items (i.e., less than $150) and caps all rental items, except oxygen concentrators and ventilators, at the purchase price. Medicaid also caps all per-day rentals at 100 days and monthly rentals at 10 months. Medicaid does not cover routine maintenance and repairs for rental equipment.

See Appendix B for more information regarding equipment and supplies included in this service area.

Table 24. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	$8,200,062	$9,029,583	$8,390,660	$9,013,400	$9,490,750	$9,846,339	4
Recipients	7,158	7,476	7,367	7,497	7,712	8,197	6
Expenditures per Recipient	$1,146	$1,208	$1,139	$1,202	$1,231	$1,201	5
Durable Medical Equipment Services Only							
Expenditures	$7,391,087	$8,285,291	$7,746,167	$8,437,833	$8,934,056	$9,242,980	25
Recipients	6,767	7,069	6,948	7,156	7,352	7,874	16
Expenditures per Recipient	$1,092	$1,172	$1,115	$1,179	$1,215	$1,174	7
Prosthetics, Orthotics, and Supplies Services Only							
Expenditures	$797,996	$757,241	$615,641	$590,930	$541,981	$610,290	-24
Recipients	628	665	625	575	584	546	-13
Expenditures per Recipient	$1,271	$1,139	$985	$1,028	$928	$1,118	-12

END-STAGE RENAL DISEASE

All medically necessary services related to renal disease care, including inpatient renal dialysis and outpatient services related to end-stage renal disease (ESRD) treatment, as well as treatment if Medicare denies coverage for an enrolled member on a home dialysis program. A hospital or free-standing facility must be a certified ESRD facility. Personal care attendants are not covered by this program.

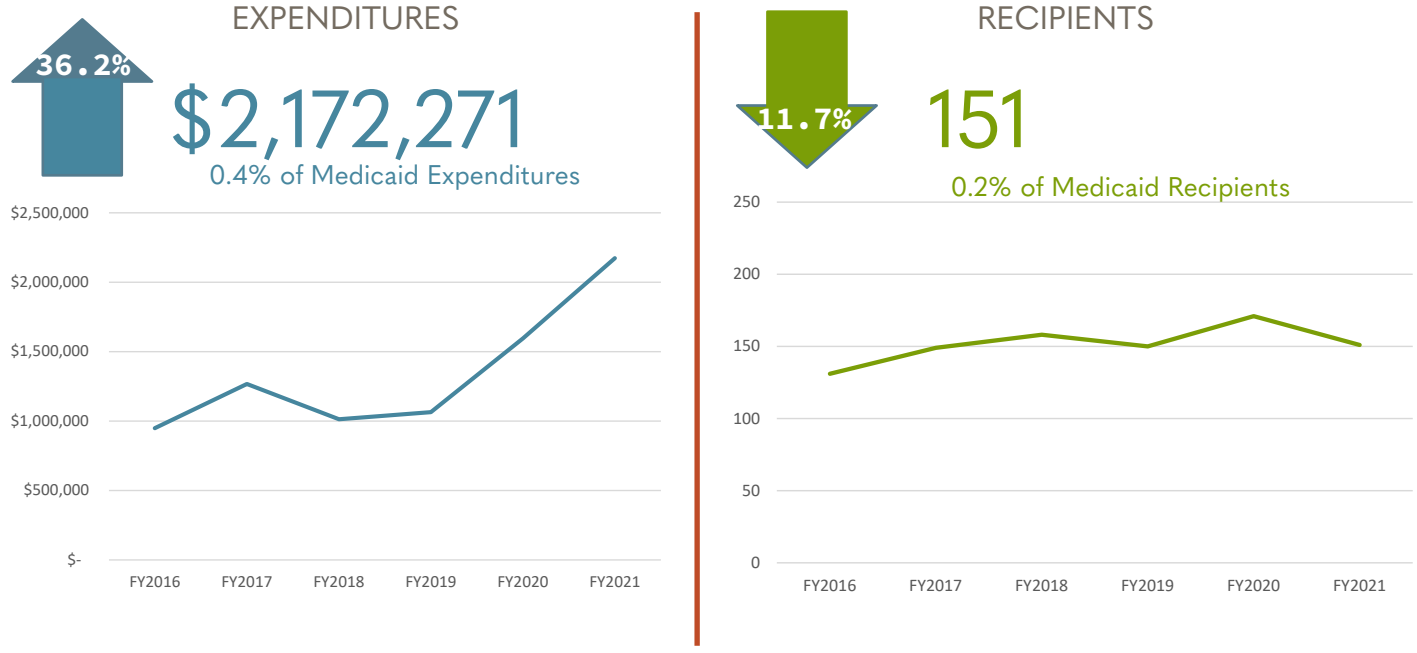


Table 25. End-Stage Renal Disease Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$948,612	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	129
Recipients	131	149	158	150	171	151	15
Expenditures per Recipient	$7,241	$8,504	$6,408	$7,089	$9,329	$14,386	99

FEDERALLY QUALIFIED HEALTH CENTER

Provides preventive primary health services when medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, dentist, orthodontist, licensed clinical psychologist, or licensed clinical social worker. The facility is designated as an FQHC by Medicare if it is located in an area designated as a "shortage area", a geographic area designated by HHS as having either a shortage of personal health services or of primary medical care professionals.

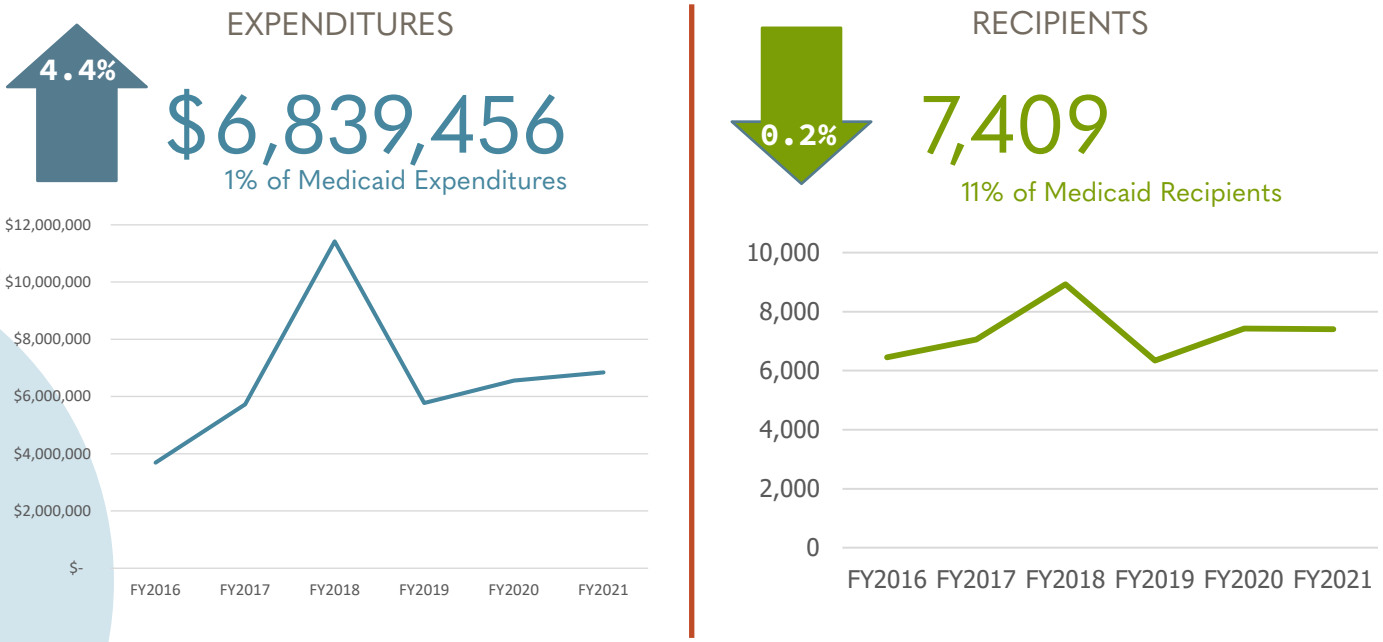


Table 26. Federally Qualified Health Center Services Summary[28]

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$3,689,548	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	85
Recipients	6,450	7,052	8,927	6,340	7,422	7,409	15
Expenditures per Recipient	$572	$812	$1,279	$911	$883	$923	61

HOME HEALTH

Services for individuals not admitted to the hospital or a nursing care facility. Must be intermittent, with three or fewer visits per day for home health aide and/or skilled nursing, with each visit lasting no more than four hours. Services must be medically necessary, ordered by a physician, and documented in a signed/dated treatment plan to be reviewed and revised as medically necessary by the attending physician at least every 60 days.

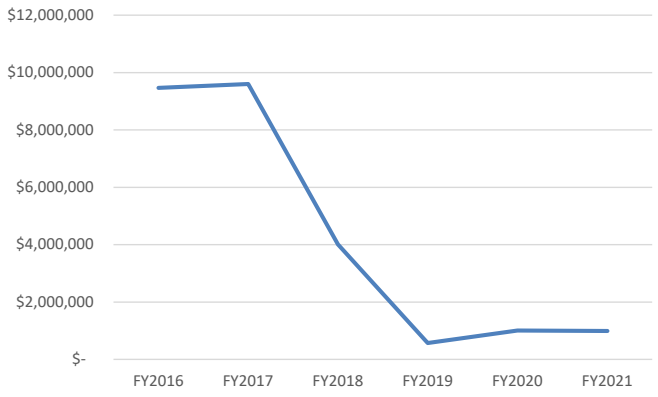
28. Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, US Department of Health and Human Services Health Resources Services Administration. Revised June 2006. http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf

EXPENDITURES

1.2%

$992,823

0.2% of Medicaid Expenditures

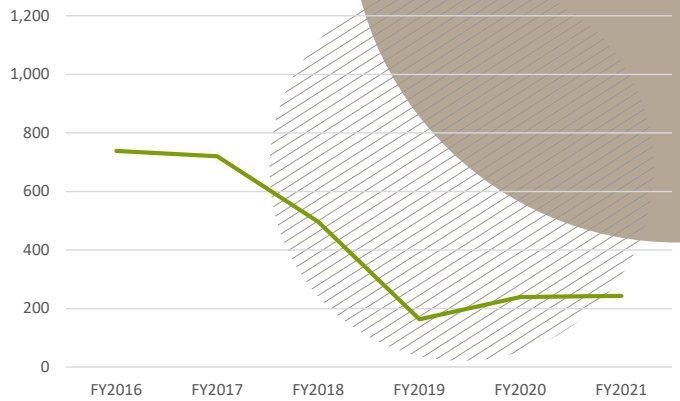


RECIPIENTS

1.7%

243

0.4% of Medicaid Recipients



Home Health agencies must provide at least two of the following services to be a licensed provider in the state of Wyoming:

- skilled nursing
- home health aide supervised by a qualified professional
- physical therapy provided by a qualified and licensed physical therapist
- speech therapy provided by a qualified therapist
- occupational therapy provided by a qualified, registered, or certified therapist
- medical social services provided by a qualified and licensed Master of Social Work (MSW) or a Bachelor of Social Work (BSW)-prepared person supervised by an MSW

The following are NOT covered Home Health services:

- homemaking
- respite care
- Meals on Wheels or home-delivered meals
- services deemed inappropriate or not cost-effective in home setting

Table 27. Home Health Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$9,467,835	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	-90
Recipients	738	720	496	163	239	243	-67
Expenditures per Recipient	$12,829	$13,329	$8,089	$3,500	$4,202	$4,086	-68

HOSPICE

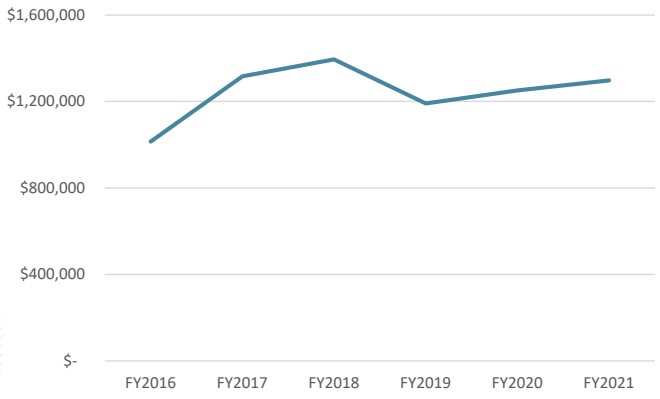
An interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying individuals. Hospice care is covered if the individual elects it and a physician certifies that the individual is terminally ill. Covered services include routine and continuous home care, inpatient respite care, and general inpatient care. Inpatient services are provided during critical periods for individuals who need a high level of care.

EXPENDITURES

3.7%

$1,297,041

0.2% of Medicaid Expenditures



RECIPIENTS

7.7%

181

0.3% of Medicaid Recipients

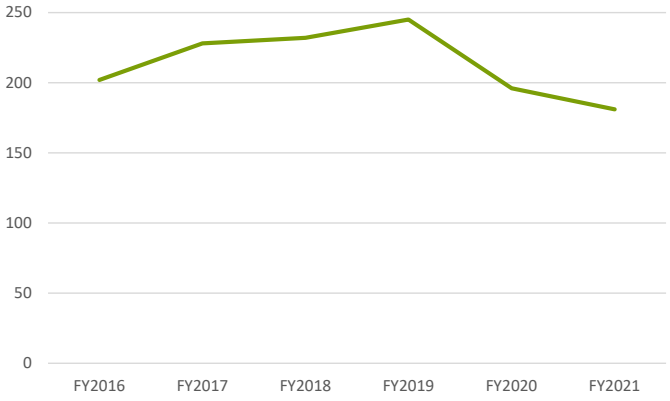


Table 28. Hospice Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$1,014,959	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	28
Recipients	202	228	232	245	196	181	-10
Expenditures per Recipient	$5,025	$5,776	$6,009	$4,858	$6,383	$7,166	43

HOSPITAL

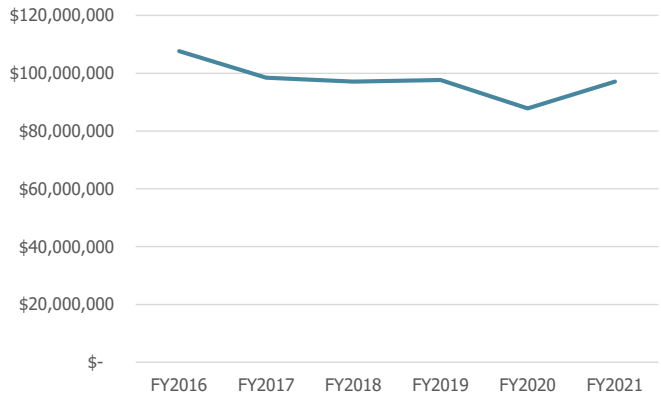
Inpatient and Outpatient hospital services

EXPENDITURES

9.8%

$97,117,803

17% of Medicaid Expenditures

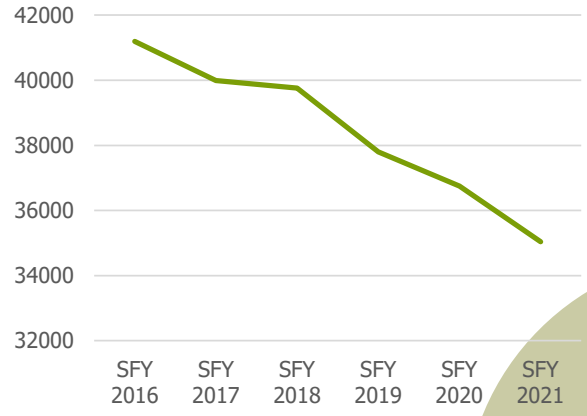


RECIPIENTS

14.9%

35,035

53% of Medicaid Recipients



QUALIFIED RATE ADJUSTMENT

The Qualified Rate Adjustment (QRA) is a supplement for qualified hospital providers. Qualifying hospitals provided state share of the payment, and Medicaid distributes corresponding Federal matching funds, along with the state share, to the participating hospitals. QRA payments are calculated using the previous SFY paid claims data.

Table 29. Total Hospital Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$107,692,150	$98,467,703	$97,086,021	$97,635,206	$87,874,110	$97,117,803	-10
Recipients	41,190	39,986	39,762	37,806	36,754	35,035	-15
Expenditures per Recipient	$2,615	$2,463	$2,442	$2,583	$2,391	$2,772	8
QRA (Federal Share)	$12,607,069	$11,202,759	$12,472,416	$13,065,161	$12,073,261	$12,969,675	3
Total Expenditures w/ QRA	$120,299,219	$109,670,462	$109,558,437	$110,700,367	$99,947,371	$123,094,959	2

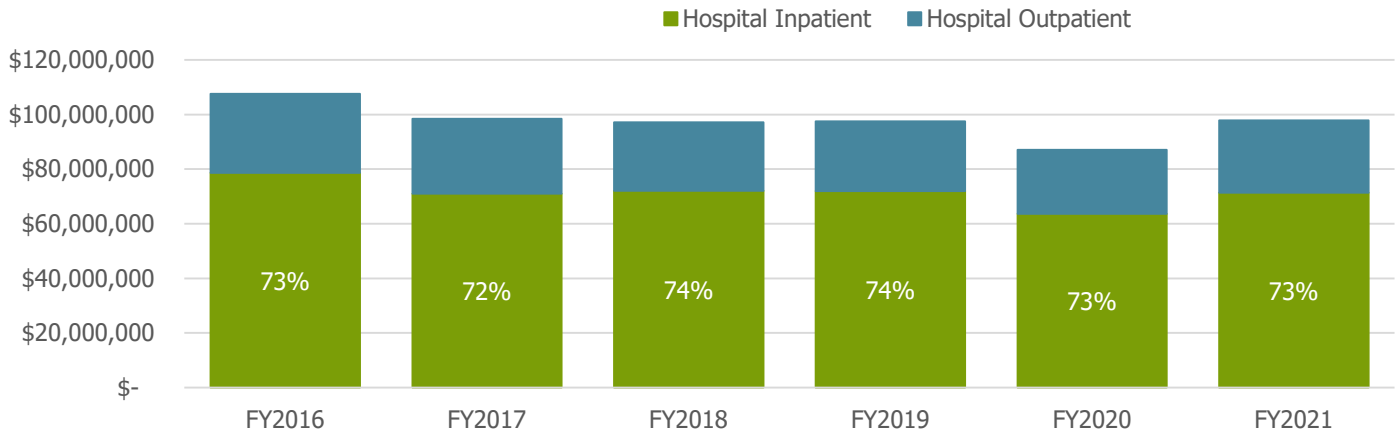


Figure 19. Hospital Inpatient-Outpatient Breakdown History by Expenditures

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Eligible hospitals who serve a disproportionate number of low-income individuals also receive **DSH** payments as required by Federal law. These payments are capped according to state-specific allotments and are paid to all Wyoming hospitals.

INPATIENT SERVICES

Medicaid covers inpatient hospital services with the exception of alcohol and chemical rehabilitation services, cosmetic surgery, and experimental services. Surgical procedures must be medically necessary, and may not be covered if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the individual.

Table 30. Inpatient Hospital Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$78,575,068	$71,022,272	$72,073,654	$71,923,532	$63,651,012	$71,378,127	-9
Recipients	10,203	10,262	9,281	8,810	10,736	8,312	-19
Expenditures per Recipient	$7,701	$6,921	$7,766	$8,164	$5,929	$8,587	12
QRA (Federal Share)	$3,143,380	$2,200,706	$3,010,897	$3,942,199	$4,038,698	$3,151,019	0.2
Total Expenditures w/ QRA	$81,718,448	$73,222,978	$75,084,551	$75,865,731	$67,689,710	$77,717,063	-5

OUTPATIENT SERVICES

Medicaid covers outpatient hospital services, including emergency room, surgery, laboratory, radiology, and other testing services. For individuals over age 21, visits to hospital outpatient departments are limited to a maximum of 12 per calendar year. There are no limits for Medicare crossovers, children under age 21, or for visits for family planning, Health Check services, and emergency room.

Table 31. Outpatient Hospital Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$28,975,050	$27,373,462	$25,021,868	$25,558,107	$23,383,212	$26,453,299	-9
Recipients	38,990	37,523	37,875	35,935	33,955	33,134	-15
Expenditures per Recipient	$743	$730	$661	$711	$689	$798	7
QRA (Federal Share)	$9,463,689	$9,002,053	$9,461,519	$9,122,962	$8,034,563	$9,808,656	7
Total Expenditures w/ QRA	$38,438,739	$36,375,515	$34,483,387	$34,681,069	$31,417,775	$46,104,543	20

For each unit of service, reimbursement equals the scaled relative weight[29] for the **Ambulatory Payment Classification (APC)**, multiplied by a conversion factor.[30] When multiple units of service and different services are provided, reimbursements are subject to discounting and unit limitations. This is designed to reimburse hospitals based on the resources used to provide services. Medicaid uses 3 conversion factors by hospital type: General Acute, Critical Access, and Children's Hospitals.

APC APPLIES TO[30]

- Significant outpatient procedures
- Ancillary services
- Drugs
- Select laboratory services
- Radiology
- Select DME, Prosthetics/Orthotics
- Select Vaccines/Immunization not reimbursed under Medicaid's physician fee schedule

EMERGENCY ROOM SERVICES

The methodology used to identify emergency room utilization has been updated in SFY 2017. This data excludes those visits that result in an inpatient admission for both visit count and expenditures. Total ER expenditures include the total amount paid on claims with a line indicating treatment in the ER. This change was made to include the cost of laboratory, radiology, and other tests that may not be performed in the ER setting, but are still associated with the ER visit.

Table 32. Emergency Room Utilization Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$14,897,552	$14,423,134	$13,198,247	$12,832,844	$11,893,916	$11,436,492	-24
Recipients	24,948	24,651	23,631	22,372	20,423	18,316	-27
Expenditures per Recipient	$597	$585	$559	$574	$582	$624	4
Emergency Room Visits	51,525	51,660	48,581	45,828	41,574	36,253	-30
% of Total Medicaid Expenditures	2.7%	2.6%	2.3%	2.3%	2.2%	2.0%	34

29. The scaled relative weight for an APC measures the resource requirements of the service and is based on the median cost (Medicare) of services in that APC. The conversion factor translates the scaled relative weights into dollar payment rates.
30. Some services from the APC methodology are reimbursed on separate fee schedules, as follows: select DME are covered under the DME fee schedule; select vaccines/immunizations, select radiology and mammography screening, diagnostic mammographies and therapies are covered under the Physician fee schedule; laboratory services are reimbursed on the laboratory fee schedule; and corneal tissue, dental, and bone marrow transplants, and new medical devices covered under Medicare's transitional pass-through payments are reimbursed a percent of the charges

Table 33. Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures	% Change from SFY 2020	Recipients	% Change from SFY 2020	ER Visits	% Change from SFY 2020
ABD EID	$41,085	-41	115	-21	324	-8
ABD ID/DD/ABI	$250,248	-15	637	-18	1,473	-20
ABD Institution	$9,500	17	15	0	20	18
ABD LTC	$526,721	-18	1,567	-17	3,882	-19
ABD SSI	$2,110,522	-6	2,294	-14	6,227	-17
Adults	$3,130,186	11	3,191	5	7,200	8
Children	$4,434,731	-6	8,737	-12	13,026	-16
Medicare Savings Program	$111,671	-28	892	-14	2,072	-13
Non-Citizens with Medical Emergencies	$10,552	-23	18	-22	21	-32
Pregnant Women	$758,400	8	1,045	-4	1,976	4
Screenings	$1,770	400	3	50	4	100
Special Groups	$51,106	50	21	-22	41	-20
Total	**$11,436,492**	**-3**	**18,535**	**-10**	**36,266**	**-12**

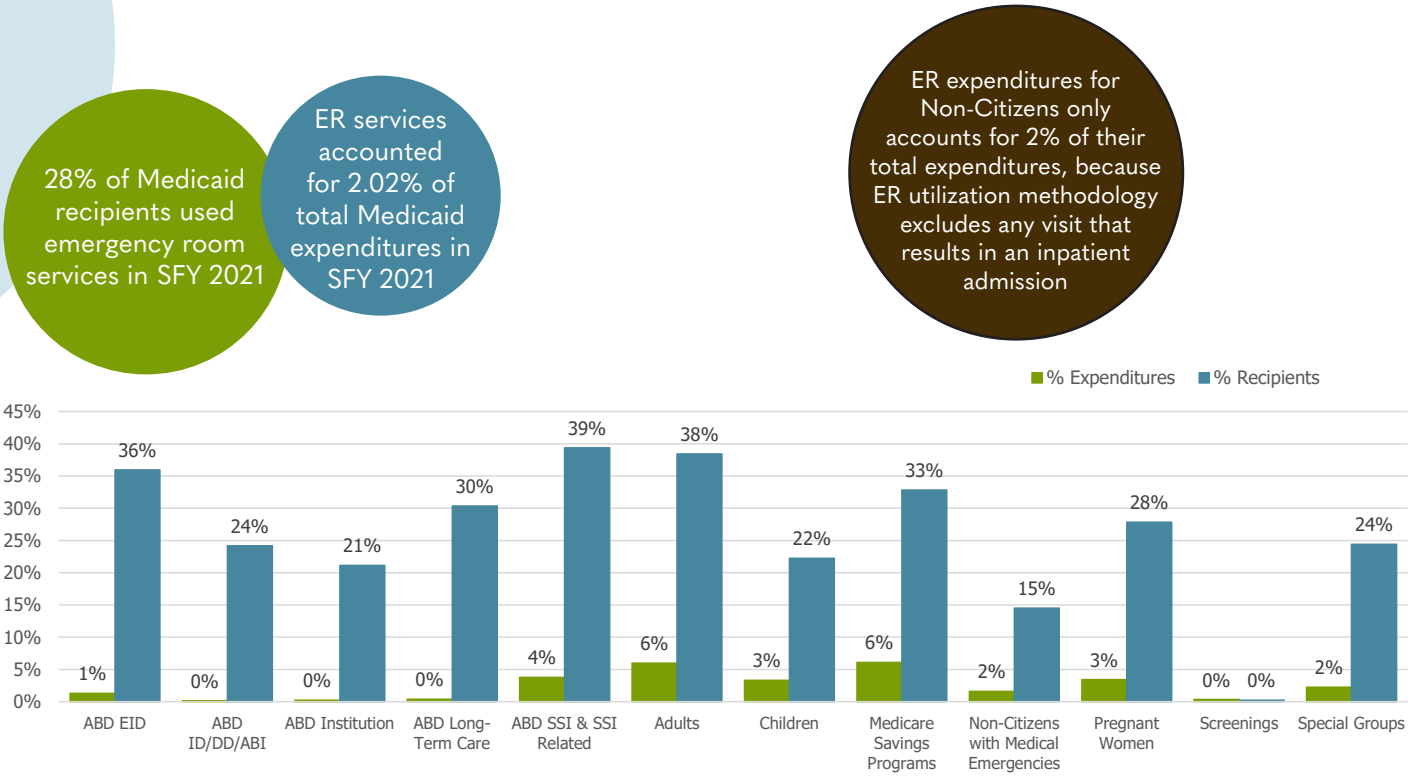


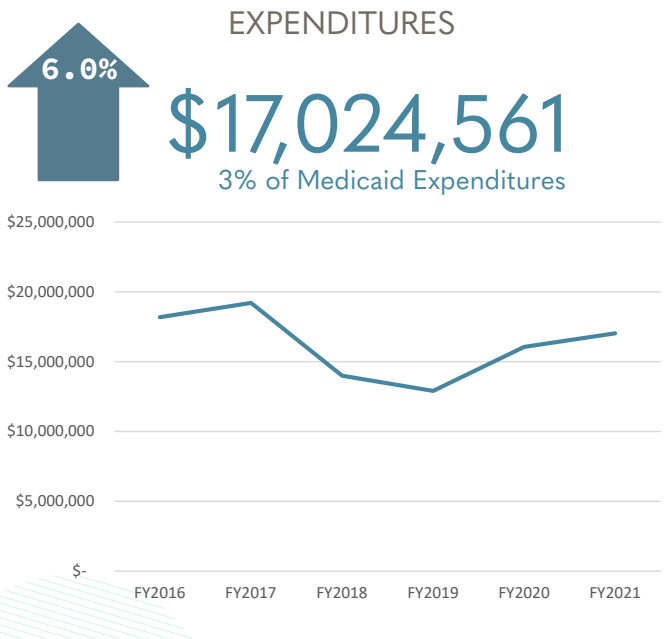
Figure 20. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Table 34. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Eligibility Category	ER Recipients	Total Medicaid Recipients	% Using ER Services	ER Expenditures	Total Medicaid Expenditures	% Paid for ER Services
ABD EID	115	320	36	$41,085	$3,168,949	1
ABD ID/DD/ABI	637	2,633	24	$250,248	$155,360,814	0
ABD Institution	15	71	21	$9,500	$4,139,118	0
ABD LTC	1,567	5,160	30	$526,721	$134,892,349	0
ABD SSI	2,294	5,828	39	$2,110,522	$56,186,651	4
Adults	3,191	8,308	38	$3,130,186	$52,267,090	6
Children	8,737	39,258	22	$4,434,731	$134,266,458	3
Medicare Savings Program	892	2,717	33	$111,671	$1,831,276	6
Non-Citizens with Medical Emergencies	18	124	15	$10,552	$657,593	2
Pregnant Women	1,045	3,753	28	$758,400	$22,087,873	3
Screenings	3	1,357	--	$1,770	$524,863	--
Special Groups	21	86	24	$51,106	$2,263,994	2
Total	**18,535**	**66,708**	**27**	**$11,436,492**	**$566,889,365**	**2**

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Services are covered only in a residential facility licensed and certified by the state survey agency as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Wyoming Life Resource Center is the sole facility in the state. This service is unique to Medicaid and is not commonly covered by other



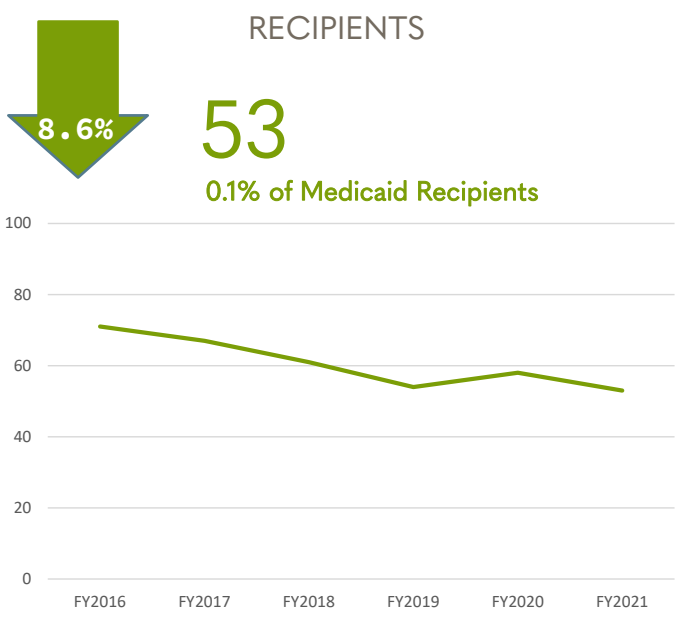


Table 35. Intermediate Care Facility for Individuals with Intellectual Disabilities Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$18,193,221	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	-6
Recipients	71	67	61	54	58	53	-25
Expenditures per Recipient	$256,243	$286,640	$229,499	$238,924	$276,878	$321,218	25

LABORATORY

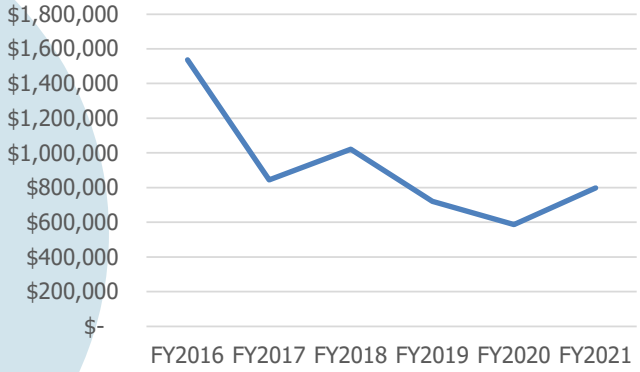
Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and treatment of the individual as specified in the treatment plan developed by the ordering practitioner.

EXPENDITURES

36.1%

$797,433

0.1% of Medicaid Expenditures



RECIPIENTS

20.0%

7,159

4% of Medicaid Recipients

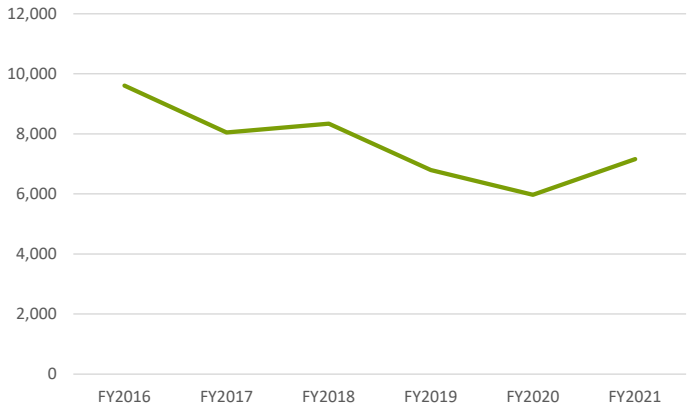
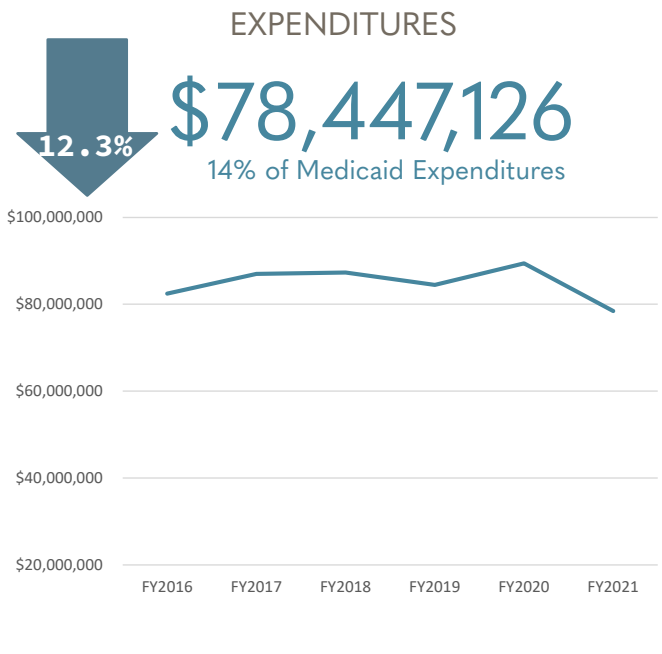


Table 36. Laboratory Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$1,536,310	$844,218	$1,020,356	$719,701	$585,977	$797,433	-48
Recipients	9,601	8,045	8,334	6,790	5,967	7,159	-25
Expenditures per Recipient	$160	$105	$122	$106	$98	$111	-30

NURSING FACILITY

Medicaid covers nursing facility services for individuals who are no longer able to live in the community. The nursing facility is an institution, or a distinct part of an institution, which is not primarily for the care and treatment of mental diseases, and provides skilled nursing care and related services to residents who require medical or nursing care, rehabilitation services for injured, disabled or sick individuals, and health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which is available to them only through institutional facilities.



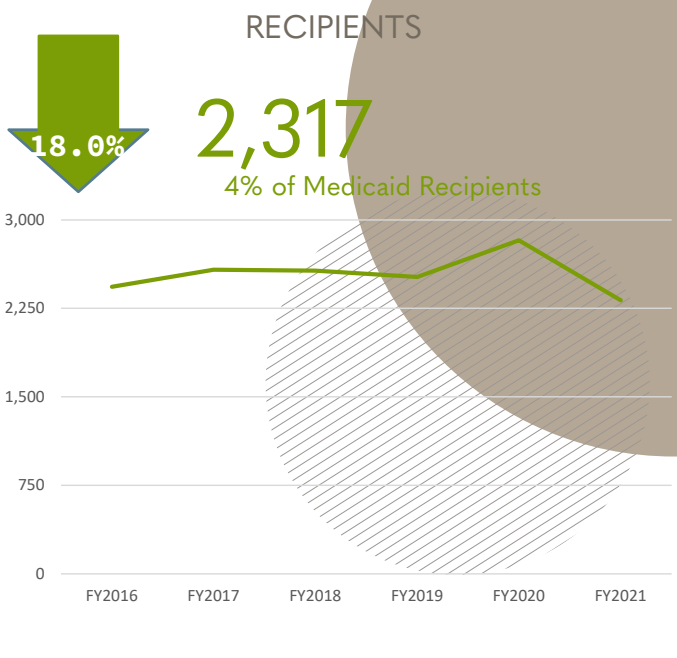


Table 37. Nursing Facility Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$82,445,811	$87,001,112	$87,304,589	$84,440,433	$89,426,962	$78,447,126	-5
Recipients	2,432	2,578	2,569	2,516	2,826	2,317	-5
Expenditures per Recipient	$33,900	$33,748	$33,984	$33,561	$31,644	$33,857	-0.1
Provider Assessment (Federal Share)	$14,689,893	$15,275,937	$16,385,303	$16,949,947	$16,936,907	$5,325,748	-64
Total Expenditures with Provider Assessment	$97,135,704	$102,277,049	$103,689,892	$101,390,380	$106,363,869	$83,772,874	-14

Per Diem Rate

Based on facility-specific cost reports
May not exceed maximum rate established by Medicaid

Includes:
Routine services (room, dietary, laundry, nursing, minor medical surgical supplies, non-legend pharmaceutical items, use of equipment & facilities)
Therapy services

Excludes:
physician visits, hospitalizations, laboratory, x-rays, and prescription drugs which are reimbursed separately.

Provider Assessment and Upper Payment Limit (UPL)

Supplemental payment for qualified nursing facilities

Based on calculations from most recent cost reports & comparisons to what would have been paid for Medicaid services under Medicare's payment principles

Assessment collected on all non-Medicare days & UPL payment paid on Medicaid days once corresponding federal matching dollars are obtained.

Extraordinary Care Per Diem Rates

Paid for services provided to a resident with extraordinary needs

Medicaid determines per case rates for extraordinary care based on relevant cost and a review of medical records.

Enhanced Adult Psychiatric Reimbursement

Provided to encourage nursing facilities to accept adults who require individualized psychiatric care

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Available in Laramie County to qualified individuals ages 55 and older as an alternative to nursing home care. Each participant has a plan of care developed by a team of healthcare professionals to improve and maintain the participant's overall health. The participant works with the team to develop and update their plan of care.

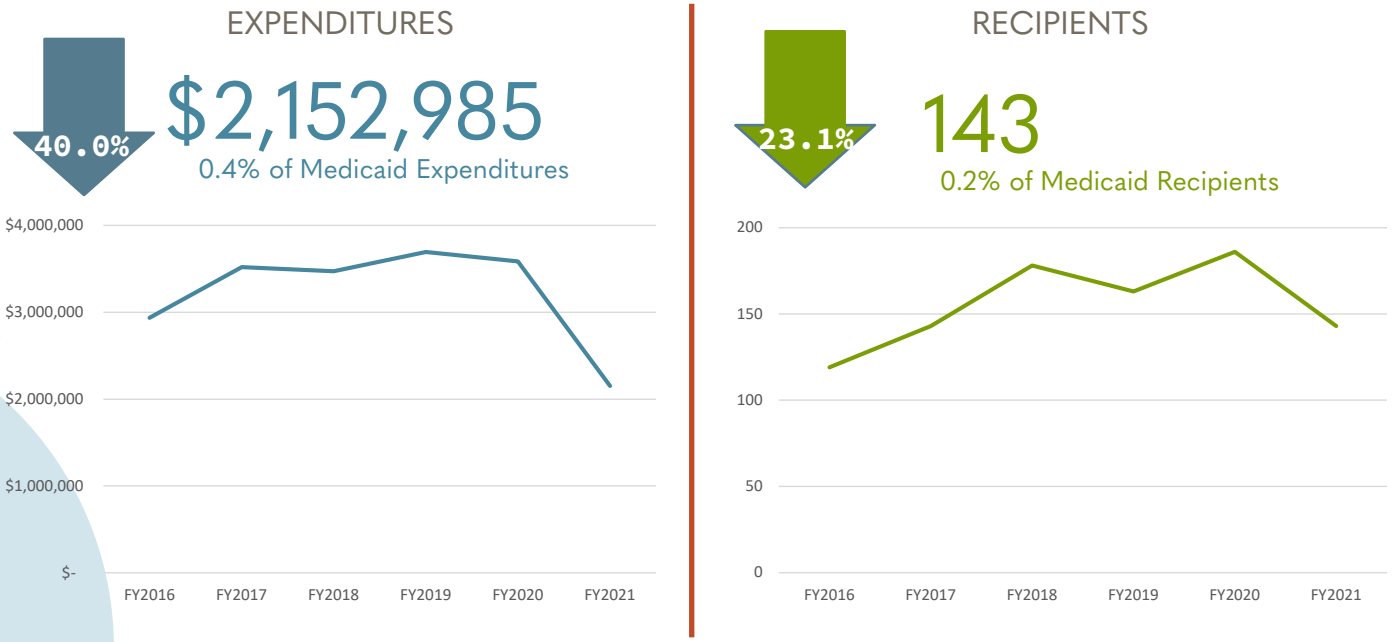


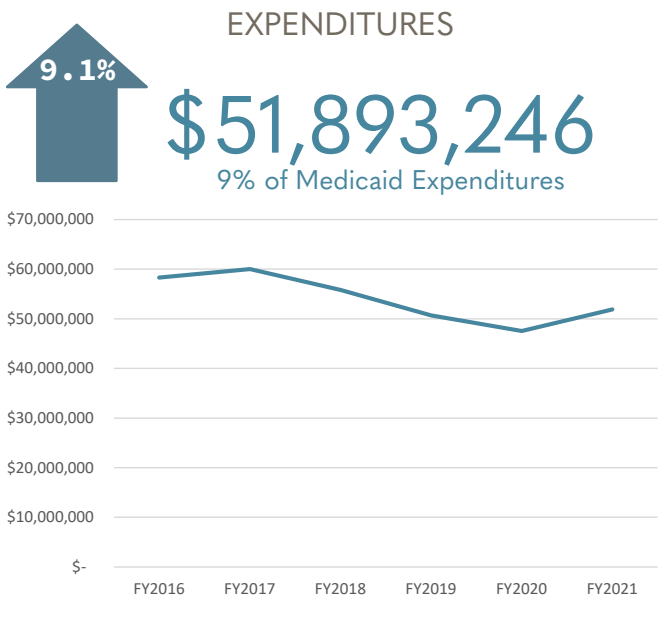
Table 38. Program for All-Inclusive Care for the Elderly Services Summary[31]

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$2,934,877	$3,520,283	$3,471,255	$3,693,978	$3,586,650	$2,152,985	-27
Recipients	119	143	178	163	186	143	20
Expenditures per Recipient	$24,663	$24,617	$19,501	$22,662	$19,283	$15,056	-39

PHYSICIAN & OTHER PRACTITIONER

Services provided by physicians and other practitioners, with the following limits:
Hospital outpatient departments, physician offices, and optometrist offices - maximum of 12 visits per calendar year for individuals over age 21
Physical, occupational, and speech therapy - maximum of 20 visits each per calendar year for individuals over age 21, with additional visits approved after review for medical necessity
There is no limit for Medicare crossovers or children under age 21; also no limit for family planning visits, Health Check services, or emergency services.

31. The PACE program was discontinued January 2021 due to budget cuts.



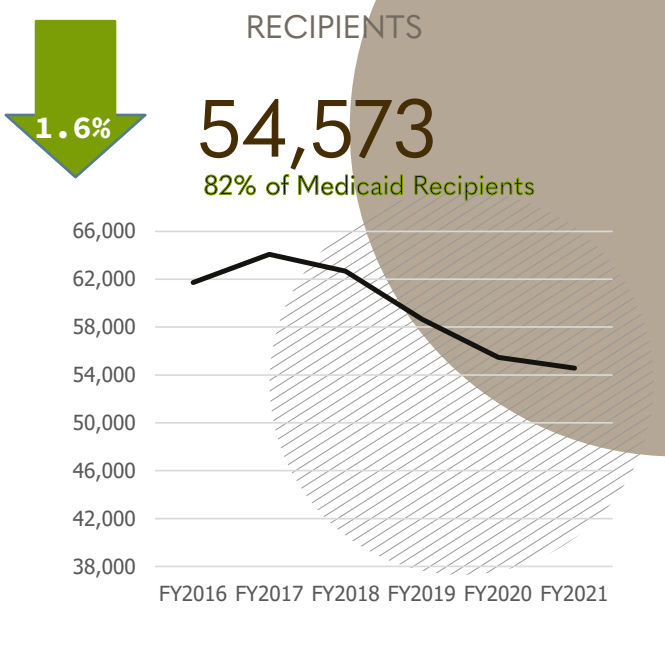


Table 39. Physician and Other Practitioner Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Total Physician and Other Practitioner Services							
Expenditures	$58,278,406	$60,013,763	$55,788,175	$50,649,977	$47,546,368	$51,893,246	-11
Recipients	61,722	64,072	62,680	58,646	55,470	54,573	-12
Expenditures per Recipient	$944	$937	$890	$864	$857	$951	1
Physician Only Services							
Expenditures	$50,015,210	$51,857,906	$49,001,617	$45,268,820	$42,053,665	$45,805,644	-8
Recipients	60,966	63,360	62,137	58,029	54,641	53,716	-12
Expenditures per Recipient	$820	$818	$789	$780	$770	$853	4
Other Practitioner Services							
Expenditures	$8,263,196	$8,155,858	$6,796,557	$5,389,957	$5,494,119	$6,087,603	-26
Recipients	9,127	8,732	7,242	7,242	7,793	8,421	-8
Expenditures per Recipient	$905	$934	$744	$744	$723	$723	-20

OTHER PRACTITIONERS INCLUDE:
Physical Therapists
Occupational Therapists
Speech-Language Pathologists
Podiatrists
Nurse Practitioners
Nurse Midwives
Nurse Anesthetists
Audiologists

RESOURCE-BASED RELATIVE VALUE

Used to reimburse medical services provided by physicians, physician assistants, physical and occupational therapists, ophthalmologists, and nurse practitioners. Based on estimates of the costs of resources required to provide physician services using a relative value unit (RVU) and conversion factor.

RVU x Conversion Factor = fee schedule rate

RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, taking into consideration the time and intensity of the physician's effort, and the physician's practice and malpractice expenses. Services provided by anesthesiologists are reimbursed using RVUs developed and published by the American Society of Anesthesiologists.

PRESCRIPTION DRUGS

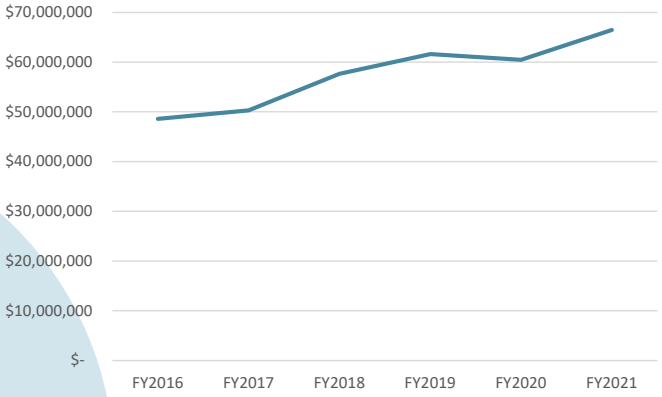
Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most individuals. Exceptions may apply for specific products or conditions.

EXPENDITURES

9.9%

$66,453,925

12% of Medicaid Expenditures



RECIPIENTS

7.3%

34,291

51% of Medicaid Recipients

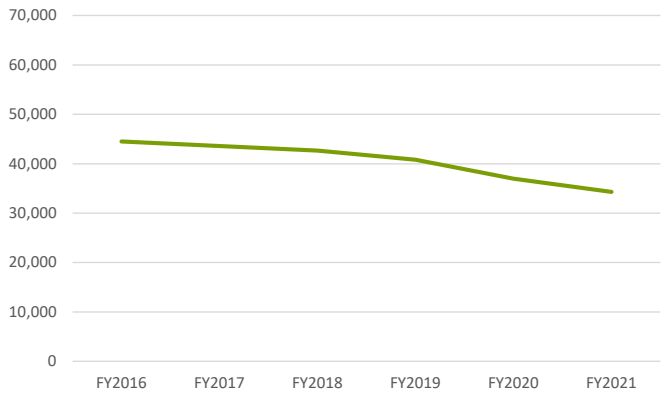


Table 40. Prescription Drug Services Summary[32]

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$48,597,364	$50,300,175	$57,642,641	$61,612,808	$60,473,215	$66,453,925	37
Recipients	44,522	43,599	42,669	40,801	36,997	34,291	-23
Expenditures per Recipient	$1,092	$1,154	$1,351	$1,510	$1,635	$1,938	78

137

specific drug classes designated as preferred drugs in SFY 2021

Drug Utilization Review (DUR) program ensures individuals receive appropriate, medically necessary medications. More information is available in the Subprograms section of this report.

Table 41. Pharmacy Cost Avoidance - SFY 2021

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$11,656,160
State Maximum Allowable Cost (SMAC)	$1,628,586
Program Integrity Cost Avoidance	$6,467,105
Total	**$19,751,851**

32. Data includes expenditures for pharmacies only and does not take into account rebate amounts.

DRUG REBATE PROGRAM

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Requires drug manufacturers have national rebate agreement with HHS Secretary. For a prescription drug to be covered, Medicaid must receive an OBRA rebate for it. This federal mandate provides Medicaid the opportunity to receive greatly discounted products, similar to those offered to large purchases in the marketplace.

Medicaid is a member of the Sovereign States Drug Consortium (SSDC), a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA.

$6.47 million

collected in J-Code rebates [33] from drug manufacturers for physician-administered or injectable drugs

Table 42. Prescription Drug Rebates History

	Rebate (millions)
SFY 2012	$19.3
SFY 2013	$19.4
SFY 2014	$21.4
SFY 2015	$20.1
SFY 2016	$31.4
SFY 2017	$27.7
SFY 2018	$30.4
SFY 2019	$29.3
SFY 2020	$27.2
SFY 2021	$33.5

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

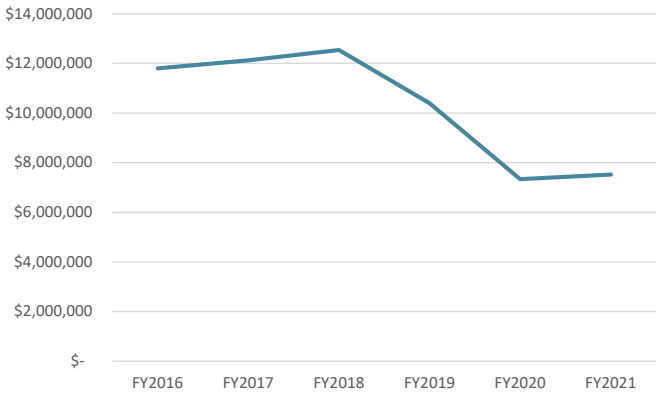
Medicaid covers psychiatric residential treatment for individuals under the age of 21 at a Psychiatric Residential Treatment Facility (PRTF), a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents under the direction of a physician, with a goal of improving the resident's condition or preventing further regression so services will no longer be needed.

EXPENDITURES

2.5%

$7,517,488

1% of Medicaid Expenditures

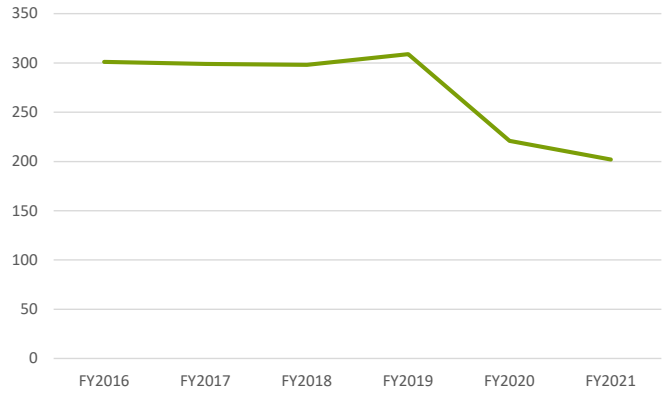


RECIPIENTS

8.6%

202

0.3% of Medicaid Recipients



33. J-code rebates are mandated by the Deficit Reduction Act of 2005

Table 43. Psychiatric Residential Treatment Facility Services Summary[34]

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$11,797,657	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	-36
Recipients	301	299	298	309	221	202	-33
Expenditures per Recipient	$39,195	$40,541	$42,073	$33,629	$33,188	$37,215	-5

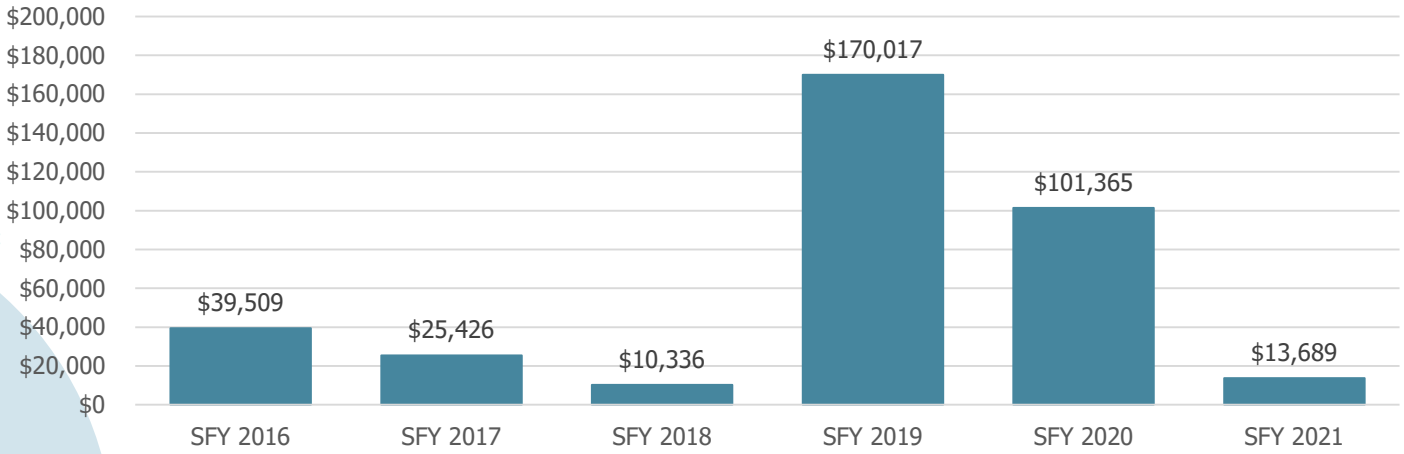
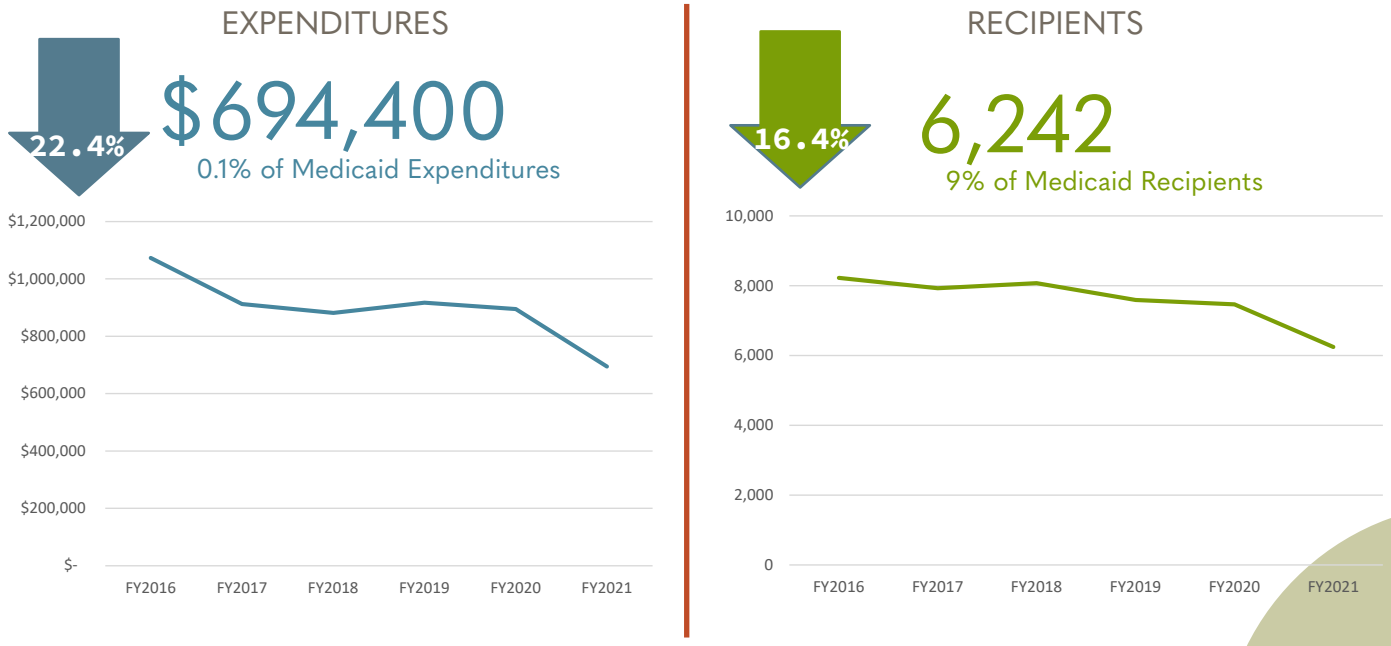


Figure 21. State General Funds-Court Ordered Psychiatric Residential Treatment Facility (PRTF) Placement (Services with Incorrect Language or No Medical Necessity) Summary

PUBLIC HEALTH OR WELFARE

Physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic. These services must be provided directly by a physician or a public health nurse under a physician's immediate supervision, such as when the physician has seen the client and ordered the service.



34. Due to court-ordered placements not complying with CMS rules, beginning with SFY 2013 Medicaid PRTF placements decreased as these placement orders did not qualify for federal matching funds. This led to significant increases in State General Fund only placements (expenses paid for by DHCF but not included in the Medicaid budget). See Figure 21.

Table 44. Public Health or Welfare Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$1,072,715	$912,444	$881,179	$917,179	$894,081	$694,400	-35
Recipients	8,222	7,928	8,072	7,590	7,465	6,242	-24
Expenditures per Recipient	$130	$115	$109	$121	$120	$111	-15

PUBLIC HEALTH, FEDERAL

These services are provided to the American Indian/Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing comprehensive primary care and related services to the American Indian/Alaska Native Population. Services provided by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

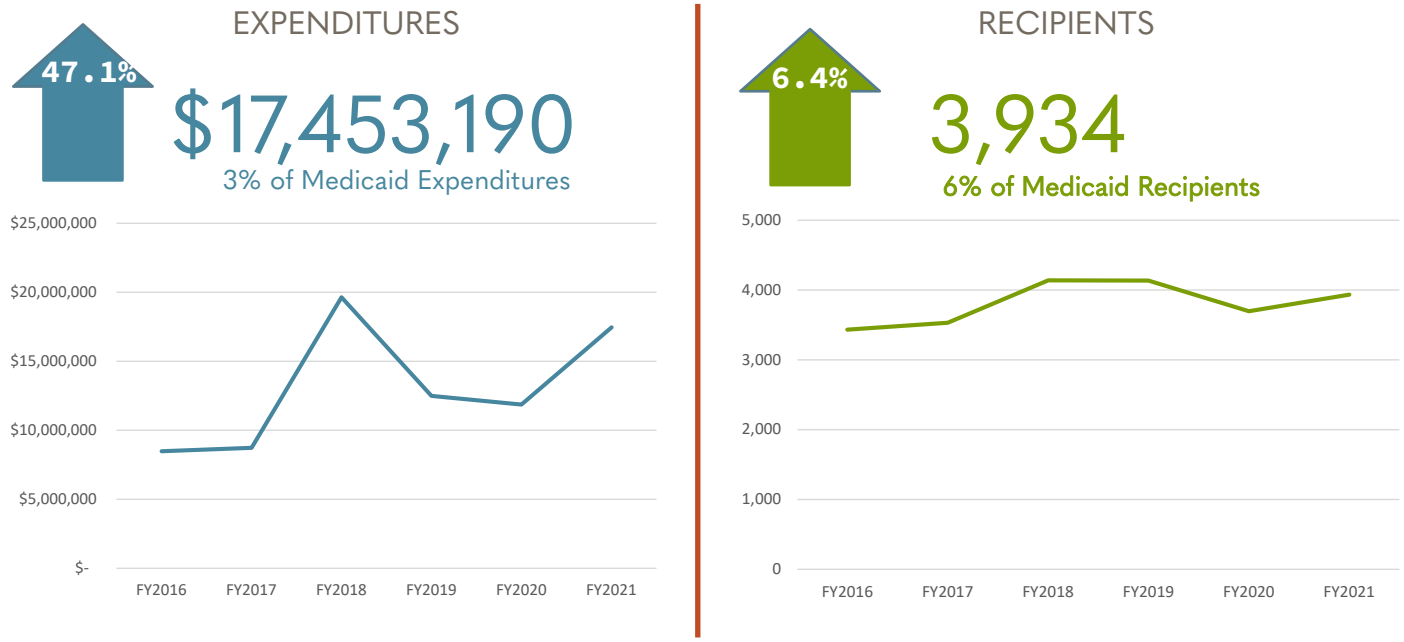


Table 45. Public Health, Federal Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$8,479,944	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	106
Recipients	3,433	3,531	4,138	4,135	3,696	3,934	15
Expenditures per Recipient	$2,470	$2,469	$4,743	$3,020	$3,210	$4,436	80

RURAL HEALTH CLINIC

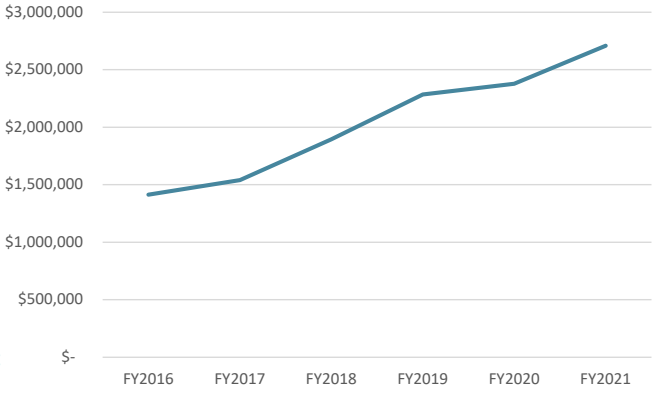
Primary care services provided at a Rural Health Clinic, as designated by Medicare if it is located in a "shortage area", a geographic area designated by the HHS as having a shortage of personal health services or primary medical care professionals. Medicaid covers services provided by a physician, nurse practitioner, certified nurse midwife, clinical psychologist, certified social worker, dentist, orthodontist, and physician assistant, as well as services and supplies incident to a physician's service.

EXPENDITURES

13.9%

$2,708,379

0.5% of Medicaid Expenditures



RECIPIENTS

7.3%

5,967

9% of Medicaid Recipients

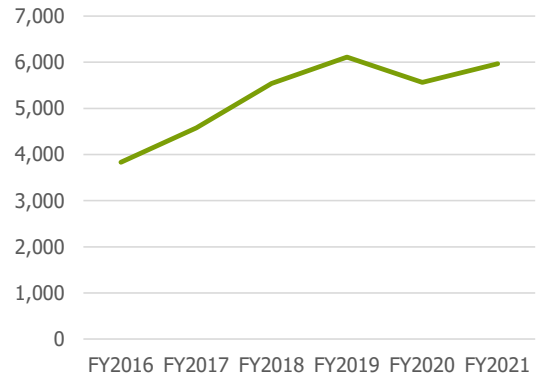


Table 46. Rural Health Clinic Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$1,413,842	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	92
Recipients	3,835	4,577	5,541	6,113	5,562	5,967	56
Expenditures per Recipient	$369	$337	$342	$374	$427	$454	23

VISION

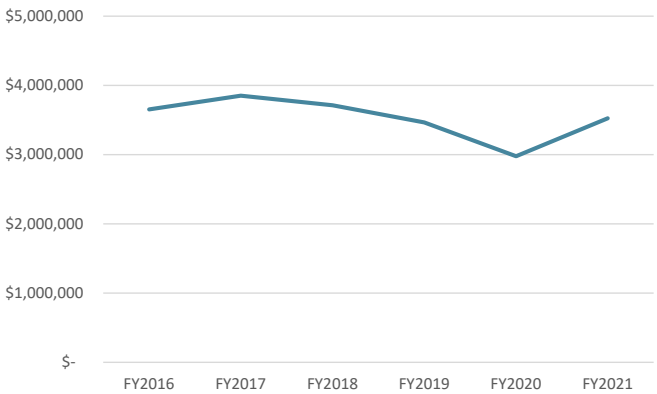
Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists, with services dependent on recipient age. Children receive services to correct and maintain healthy vision, including eyeglasses (frames, frame parts, and lenses) and vision therapy based on diagnosis codes. Adults may receive services to treat an eye injury or eye disease. Vision services provided by ophthalmologists are included in the Physician and Other Practitioners section of this report.

EXPENDITURES

18.5%

$3,526,355

1% of Medicaid Expenditures



RECIPIENTS

18.4%

15,016

23% of Medicaid Recipients

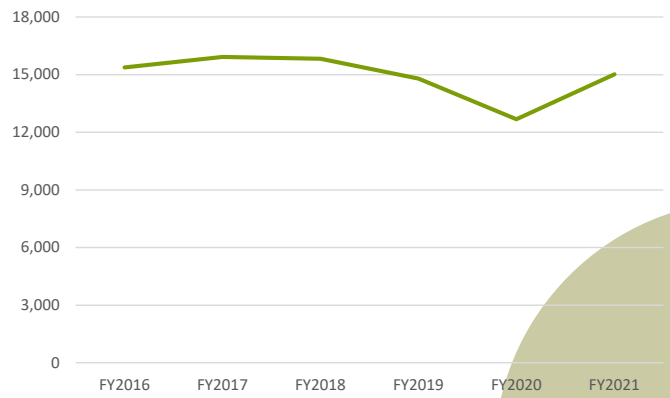


Table 47. Vision Services Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$3,652,188	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355	-3
Recipients	15,369	15,921	15,821	14,790	12,680	15,016	-2
Expenditures per Recipient	$238	$242	$235	$234	$235	$235	-1

WAIVERS

Medicaid offers various waivers with approval from CMS to selectively "waive" one or more Medicaid requirements to allow greater flexibility in the Medicaid program.

CME also provides services to children enrolled in non-Medicaid state-funded institutional foster care. The total SFY 2021 expenditures and recipient count shown in Table 22 includes $60,836 for those 12 children.

MEDICAID WAIVERS

HOME & COMMUNITY BASED SERVICES WAIVERS

Community Choices
Children's Mental Health
Acquired Brain Injury
Comprehensive
Supports

Pregnant by Choice (section 1115 waiver)

HOME & COMMUNITY BASED SERVICES WAIVERS

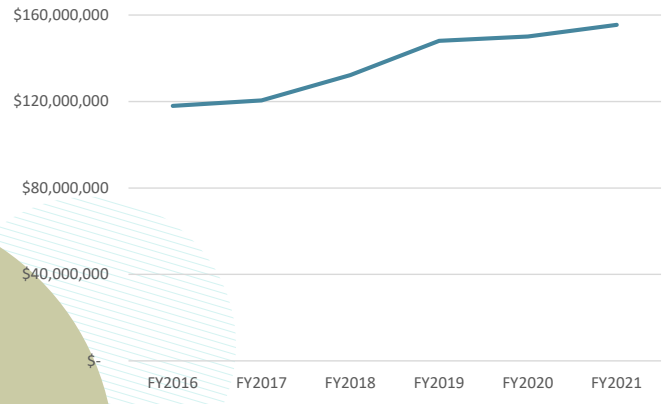
These waivers provide care in the home and community to the elderly and disabled, intellectually disabled, developmentally disabled and certain other disabled adults enrolled in Medicaid.

EXPENDITURES

3.6%

$155,475,943

27% of Medicaid Expenditures

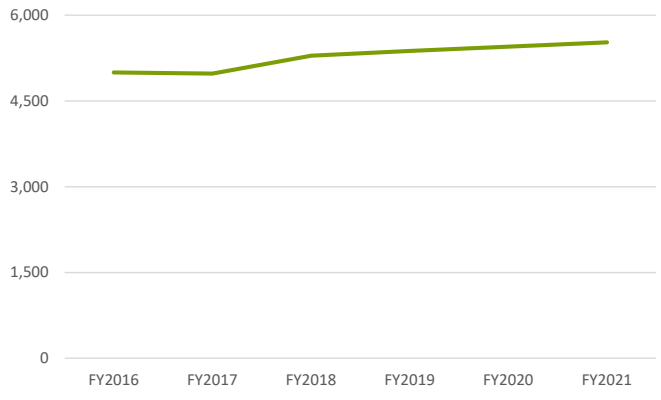


RECIPIENTS

1.3%

5,514

1% of Medicaid Recipients



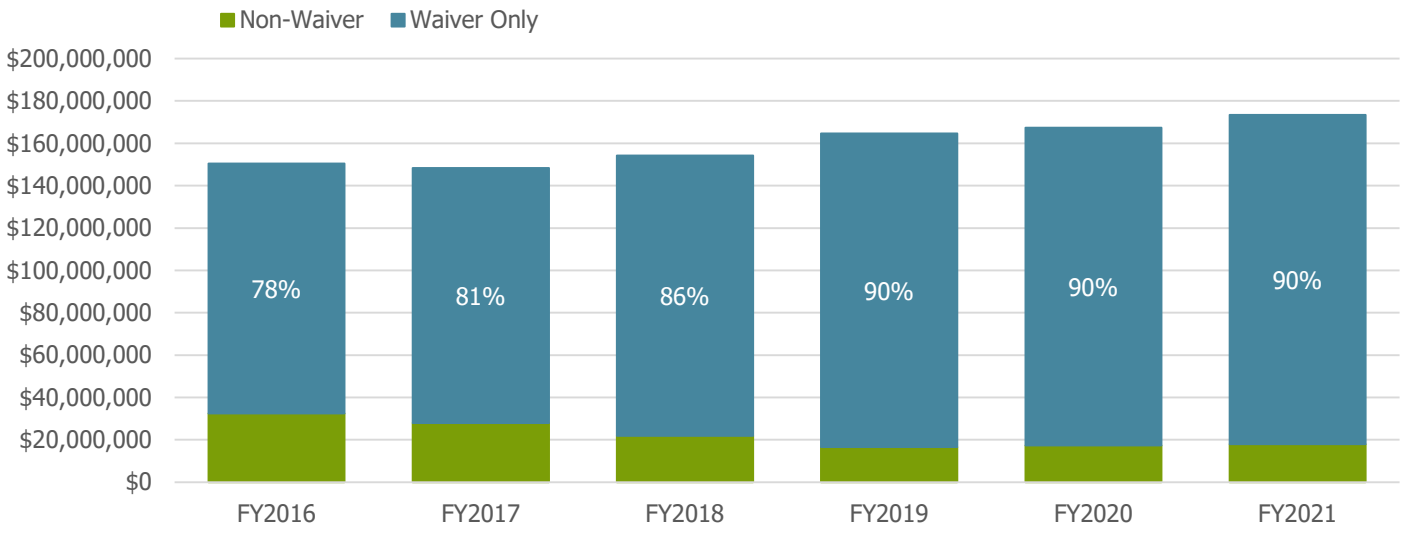


Figure 22. Waiver vs Non-Waiver Expenditures History

Table 48. Home and Community Based Services Waiver Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Waiver Only Services							
Expenditures	$117,955,631	$120,444,960	$132,243,321	$148,078,894	$150,076,885	$117,955,751	32
Recipients	4,817	4,958	5,144	5,317	5,425	5,514	14
Expenditures per Recipient	$24,487	$24,293	$25,708	$27,850	$27,664	$29,948	15
% Waiver-Only of Total Waivers	78%	81%	86%	90%	90%	90%	0
Non-Waiver Services							
Expenditures	$32,471,001	$27,954,381	$21,956,278	$16,584,581	$17,350,327	$17,984,589	-45
Recipients	4,919	5,132	5,306	5,418	5,697	5,596	14
Expenditures per Recipient	$6,601	$5,447	$4,138	$3,061	$3,046	$3,214	-51
Total Waiver							
Expenditures	$150,426,752	$148,399,341	$154,199,599	$164,663,475	$167,427,212	$155,475,943	15
Recipients	5,070	5,286	5,479	5,630	5,891	5,792	14
Expenditures per Recipient	$29,670	$28,074	$28,144	$29,248	$28,421	$28,197	1

Adult ID/DD

Child ID/DD

ABI

Adult and Child ID/DD waiver individuals have completed transition to new Comprehensive and Supports waivers.

ABI waiver individuals completed the transition to the new waivers in April 2018.

Comprehensive

Supports

Additionally children enrolled in the Children's Mental Health waiver now receive all their case management services through the Care Management Entity service, highlighted earlier in this report.

Due to the above changes, the Adult ID/DD, Child ID/DD, and Children's Mental Health waivers are included in Table 50 to show their historical trends; however, these waivers will not be reported in further detail in this section.

Figures 20 and 21 show the historical change in expenditures as the transition to Comprehensive and Supports waivers have been implemented. From SFY 2016 to SFY 2021, total expenditures for these populations have increased 9%, with non-waiver expenditures decreasing by 60%.

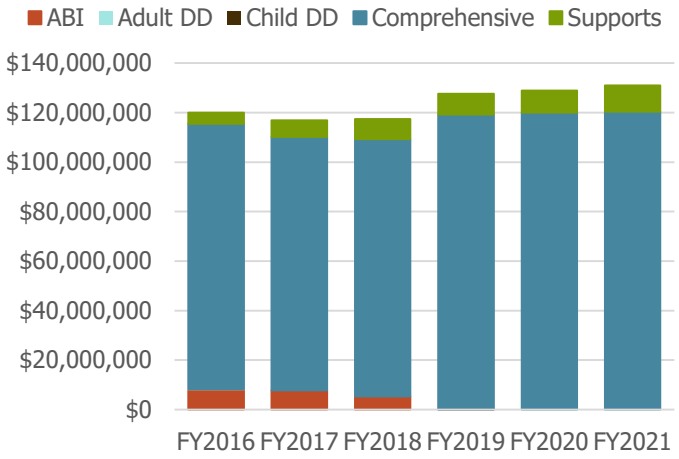


Figure 23. Total Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

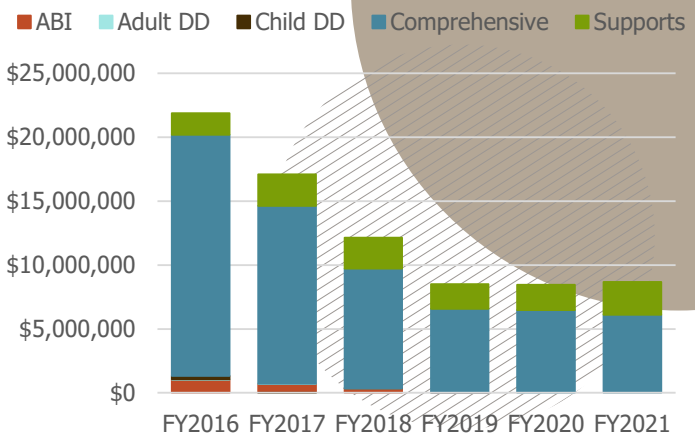


Figure 24. Non-Waiver Services Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

Table 49. Home and Community Based Services Waiver Expenditures History by Waiver

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Waiver Only Services						
ABI	$6,748,171	$6,960,882	$4,948,202	$15,008	--	--
Adult ID/DD	$1,868	$1,565	--	--	--	--
Child ID/DD	$179,173	--	--	--	--	--
Children's Mental Health	$61,981	--	--	--	--	--
Community Choices	$19,806,505	$20,587,194	$26,930,997	$28,957,689	$29,661,574	$33,146,033
Comprehensive	$88,377,484	$88,517,064	$94,568,471	$112,673,503	$113,532,461	$114,273,065
Supports	$2,780,450	$4,378,255	$5,795,651	$6,432,694	$6,882,850	$8,056,846
Non-Waiver Services						
ABI	$1,045,596	$714,600	$347,375	$5,160	--	--
Adult ID/DD	$9,953	$1,035	$36	--	--	--
Child ID/DD	$268,404	-$4,650	$218	--	--	--
Children's Mental Health	$636,077	$451,590	$653,713	$435,708	$290,891	$502,477
Community Choices	$9,947,820	$10,411,527	$9,167,122	$7,631,127	$8,594,532	$8,817,049
Comprehensive	$18,883,901	$13,921,993	$9,376,098	$6,567,542	$6,483,800	$6,107,916
Supports	$1,679,251	$2,458,285	$2,411,717	$1,945,044	$1,981,104	$2,557,147
Total Waiver						
ABI	$7,793,766	$7,675,482	$5,295,577	$20,168	--	--
Adult ID/DD	$11,820	$2,600	$36	--	--	--
Child ID/DD	$447,577	-$4,650	$218	--	--	--
Children's Mental Health	$698,058	$451,590	$653,713	$435,708	$290,891	$502,477
Community Choices	$29,754,446	$30,998,721	$36,098,118	$36,588,816	$38,256,106	$41,963,082
Comprehensive	$107,261,385	$102,439,057	$103,944,569	$119,241,045	$120,016,261	$120,380,980
Supports	$4,459,700	$6,836,540	$8,207,369	$8,377,738	$8,863,953	$10,613,993

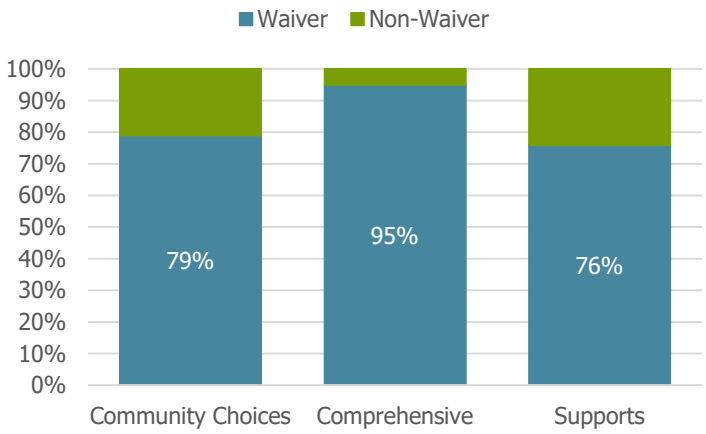


Figure 25. SFY 2021 Waiver-Only versus Non-Waiver Services by Waiver

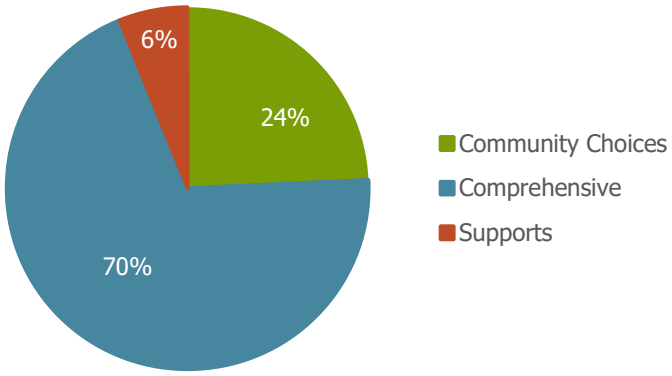
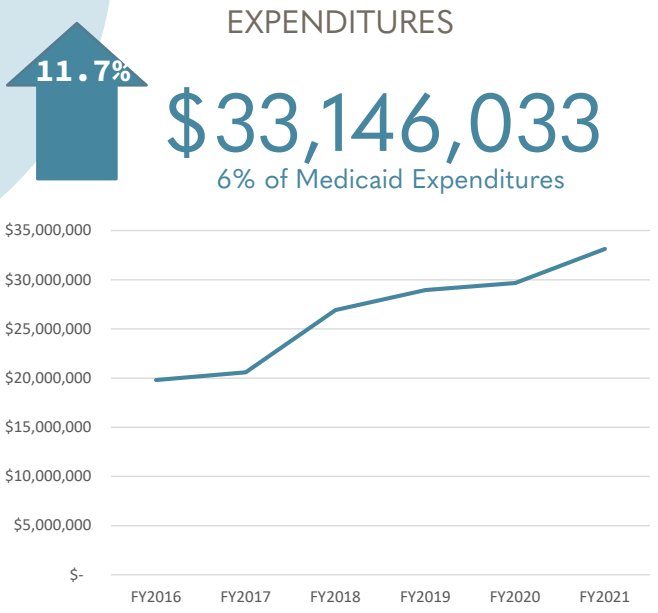


Figure 26. SFY 2021 Total Waiver Expenditure Breakdown by Waiver

COMMUNITY CHOICES WAIVER

This waiver provides in-home services and assisted living services to Medicaid enrollees 19 years of age and older who are aged, blind, or disabled and require services equivalent to nursing home level of care. This waiver was formerly the Long-Term Care waiver, and starting in SFY 2017 added the assisted living services to replace the Assisted Living Facility waiver.



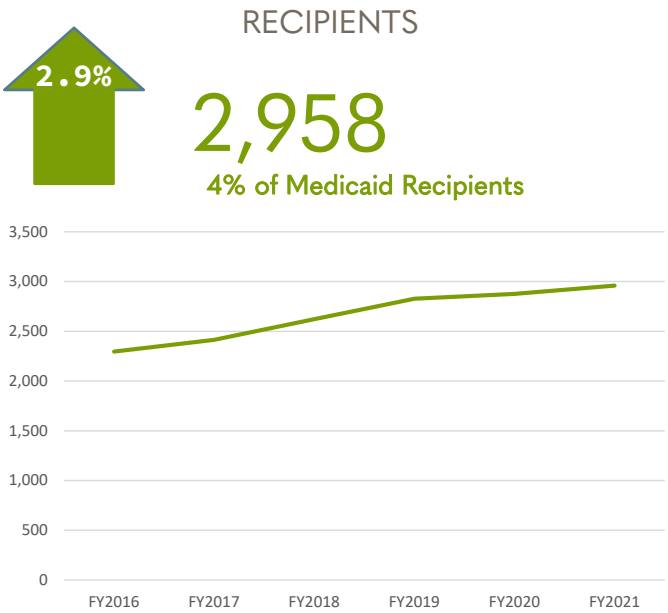
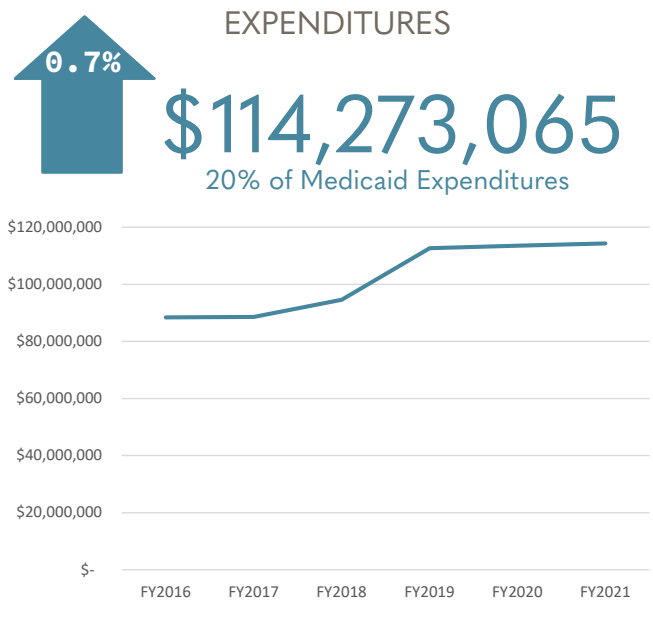


Table 50. Community Choices Waiver Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Waiver Only Services							
Expenditures	$19,801,298	$20,597,605	$26,930,997	$28,957,689	$29,661,574	$33,146,033	67
Recipients	2,295	2,414	2,622	2,828	2,875	2,958	29
Expenditures per Recipient	$8,628	$8,533	$10,271	$10,240	$10,317	$11,206	30
% Waiver-Only	67%	66%	75%	79%	78%	79%	118
Non-Waiver Services							
Expenditures	$9,947,820	$10,411,275	$9,166,911	$7,631,127	$8,594,510	$8,817,049	-11
Recipients	2,373	2,524	2,699	2,851	3,086	3,003	27
Expenditures per Recipient	$4,192	$4,125	$3,396	$2,677	$2,785	$2,936	-30
Total Waiver							
Expenditures	$29,754,446	$30,998,469	$36,097,908	$36,588,816	$38,256,084	$41,963,082	41
Recipients	2,444	2,602	2,807	2,993	3,200	3,112	27
Expenditures per Recipient	$12,174	$11,913	$12,860	$12,225	$11,955	$13,484	11

COMPREHENSIVE WAIVER

This Medicaid waiver, started in SFY 2014, funds services for individuals with intellectual or developmental disability based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool.



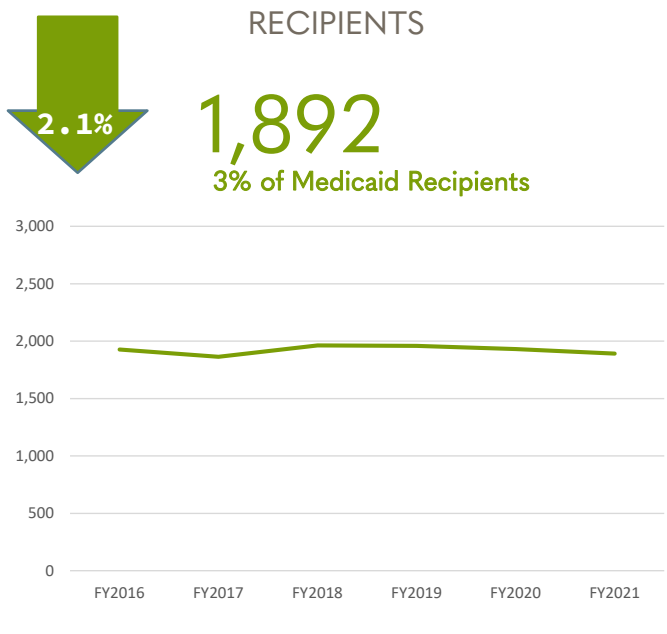


Table 51. Comprehensive Waiver Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Waiver Only Services							
Expenditures	$88,377,607	$88,527,446	$94,568,471	$112,673,503	$113,532,461	$114,273,065	29
Recipients	1,927	1,863	1,962	1,959	1,932	1,892	-2
Expenditures per Recipient	$45,863	$47,519	$48,200	$57,516	$58,764	$60,398	32
% Waiver-Only	82%	86%	91%	94%	95%	95%	0
Non-Waiver Services							
Expenditures	$18,883,901	$13,921,993	$9,376,098	$6,567,542	$6,483,800	$6,107,916	-68
Recipients	1,902	1,858	1,937	1,938	1,930	1,873	-2
Expenditures per Recipient	$9,928	$7,493	$4,841	$3,389	$3,359	$3,261	-67
Total Waiver							
Expenditures	$107,261,385	$102,439,057	$103,944,569	$119,241,045	$120,016,261	$120,380,980	12
Recipients	1,949	1,890	1,989	1,983	1,966	1,911	-2
Expenditures per Recipient	$55,034	$54,201	$52,260	$60,132	$61,046	$62,994	14

SUPPORTS WAIVER

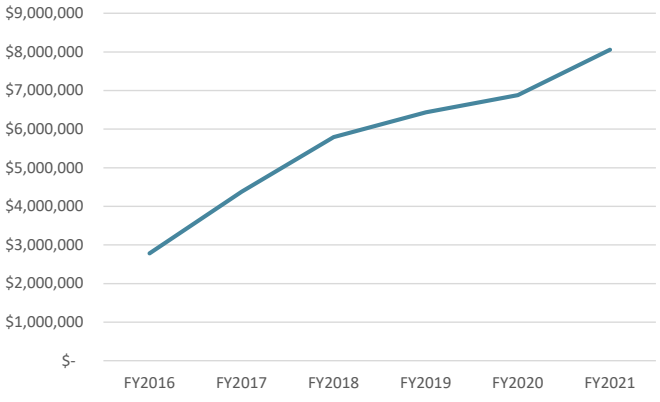
This Medicaid waiver, started in SFY 2014, provides more flexible, although capped, funding for supportive services for individuals with intellectual or developmental disability.

EXPENDITURES

17.1%

$8,056,846

1% of Medicaid Expenditures



RECIPIENTS

4.7%

674

1% of Medicaid Recipients

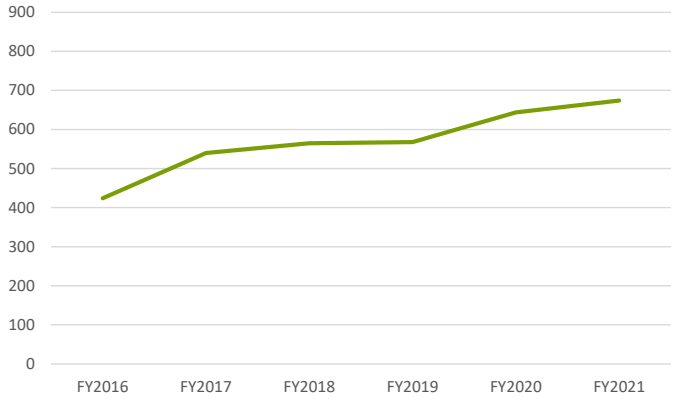
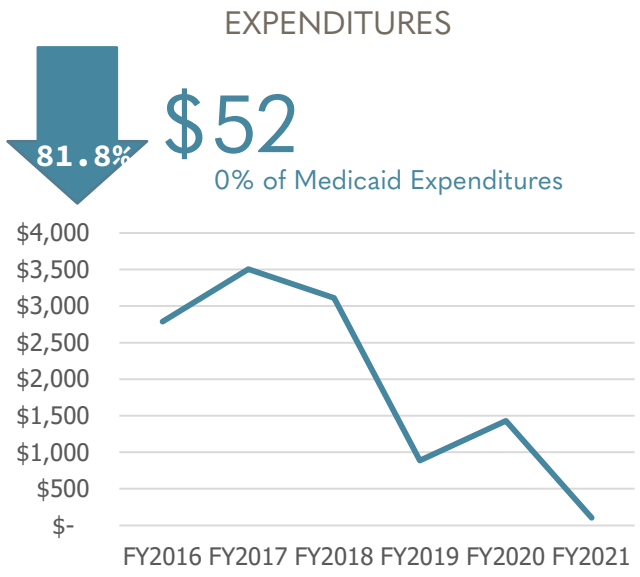


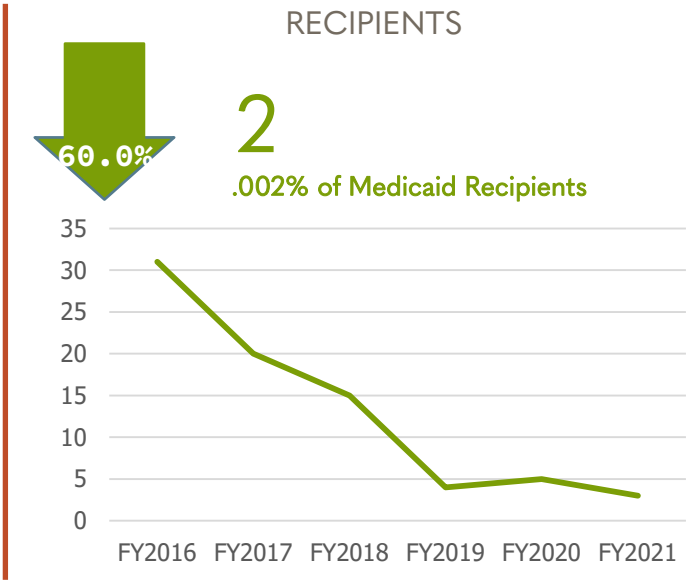
Table 52. Supports Waiver Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Waiver Only Services							
Expenditures	$2,780,450	$4,378,255	$5,795,651	$6,432,694	$6,882,850	$8,056,846	190
Recipients	424	540	565	568	644	674	59
Expenditures per Recipient	$6,558	$8,108	$10,258	$11,325	$10,688	$11,954	82
% Waiver-Only	62%	64%	71%	77%	78%	76%	-2
Non-Waiver Services							
Expenditures	$1,679,251	$2,458,285	$2,411,717	$1,945,044	$1,981,104	$2,557,147	52
Recipients	403	513	552	554	610	630	56
Expenditures per Recipient	$4,167	$4,792	$4,369	$3,511	$3,248	$4,059	-3
Total Waiver							
Expenditures	$4,459,700	$6,836,540	$8,207,369	$8,377,738	$8,863,953	$10,613,993	138
Recipients	440	555	581	584	658	682	55
Expenditures per Recipient	$10,136	$12,318	$14,126	$14,345	$13,471	$15,563	54

PREGNANT BY CHOICE WAIVER

Medicaid provides pregnancy planning services through this Section 1115 waiver with the goal of reducing the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies in order to reduce health risks to women and children and achieve cost savings. These services are available to women who have received Medicaid benefits under the Pregnant Women eligibility program and would otherwise lose Medicaid eligibility 60 days postpartum. .





Pregnant by Choice waiver services are included in the individual service sections in this report and are thus excluded from the service overview tables earlier in the report.

Table 53. Pregnant by Choice Waiver Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$2,790	$3,507	$3,113	$888	$1,428	$103	-96
Recipients	31	20	15	4	5	2	-94
Expenditures per Recipient	$90	$175	$208	$222	$286	$52	-43

SUBPROGRAMS & SPECIAL POPULATIONS

SUBPROGRAMS

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) program reviews the utilization of outpatient prescription drugs to ensure individuals are receiving appropriate, medically necessary medications which are not likely to result in adverse effects. The program was established in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). Medicaid has contracted with the University of Wyoming to administer the program, which includes a number of activities, as described below.

Pharmacy & Therapeutics Committee

Six physicians, five pharmacists, and one allied health professional along with the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and a drug information specialist from the University of Wyoming School of Pharmacy. Meets quarterly to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review, and education activities to Medicaid.

Prospective DUR

Required review of prescription claims for appropriateness prior to dispensing at the pharmacy. This review takes prior authorization policies into consideration when identifying potential issues, including, but not limited to, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and potential adverse effects.

Retrospective DUR

Ongoing review of aggregate claims data to uncover trends and review individual patient profiles to aid in monitoring for therapeutic appropriateness, over-and under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and other issues. This can lead to recommendations for prospective DUR policy, including prior authorizations, to encourage appropriate utilization at the program level. Reviewing individual patient profiles may result in educational letters to the prescriber when the reviewing Committee members determine the issue to be clinically significant to a specific patient.

Input from Medical Community

Actively solicits feedback about prior authorization policies from prescribers in Wyoming through direct mailings. Letters are sent to all specialists in affected areas, as well as a random sample of fifty general practitioners. The P&T Committee reviews all comments that are received prior to giving final approval of the policy. This allows providers an opportunity to participate in the decision-making process. Providers are encouraged to submit comments and concerns to the committee for review through public comment forms available on the DUR website. Providers may use this method to comment on both existing and new policy.

Education

Quarterly newsletters are sent to all Wyoming providers. Targeted education letters regarding duplicate benzodiazepine utilization, long and short-acting opiate utilization, and high-dose opiate utilization are also sent.

Review Clinical Evidence

The P&T Committee reviews evidence regarding the comparative safety and efficacy of medications, making recommendations to Medicaid for each reviewed class and providing input on clinical considerations included in the creation of the Medicaid Preferred Drug List (PDL).

WYOMING FRONTIER INFORMATION (WYFI) HEALTH EXCHANGE

The WYFI Health Information Exchange (HIE) system enables and supports Medicaid providers in promoting a healthier Wyoming by developing a secure, connected, and coordinated statewide health IT system that supports effective and efficient healthcare. For additional information refer to the WYFI HealthStat documentation.

Table 54. WYFI Health Exchange Outcomes Summary

WYFI Outcomes								
Performance Metric		Desired Trend	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY2020	SFY2021
Facilities	Data Contributing	⬆	N/A[35]	N/A	0	54	92	189
	View Only	⬆	N/A	N/A	0	15	100	157
WYFI Users	Unique Providers	⬆	N/A	N/A	0	27	386	3556
	Total Users	⬆	N/A	N/A	0	170	939	5446
Covered Lives in the HIE	WY Covered Lives	⬆	N/A	N/A	N/A*[36]	N/A*	210,576	357,359
	All Covered Lives	⬆	N/A	N/A	N/A*	N/A*	311,198	402,304
	Medicaid Lives Covered	⬆	N/A**[37]	N/A**	N/A**	N/A**	N/A**	34,171
# of Patient Encounters in the HIE		⬆	N/A	N/A	N/A*	N/A*	2,485,938	3,668,561
Notify Users - ADTs (Alert, Discharge, Transfer Notifications		⬆	N/A	N/A	0	0	8	62

PROMOTING INTEROPERABILITY PROGRAM

Medicaid established the Promoting Interoperability Program under the American Recovery and Reinvestment Act (ARRA) of 2009 to provide incentive payments to eligible professionals and hospitals for the adoption, implementation, upgrading, and meaningful use of an Electronic Health Record system. Payments for this program are paid with 100% Federal Funds. This program was discontinued 9/1/2021.

Professionals must have 30% Medicaid patients (20% for pediatricians) and increase utilization of the EHR to become and remain eligible to receive up to $63,750 over the 6 years they choose to participate.

Hospitals must have 10% Medicaid patients and increase utilization of the EHR to become and remain eligible, with the total incentive paid over the course of three years.

35. N/A Reporting tool was not available until SFY 2020.
36. N/A* Indicates no data since the program did not start until late SFY 2018.
37. N/A** indicates this data was not tracked prior to SFY 2021.

ADMINISTRATIVE TRANSPORTATION

Medicaid covers the cost of transportation to and from medical appointments if the appointment is medically necessary, it is approved by WDH at least 3 business days in advance, and the least costly mode of transportation is selected. Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided. Per diem expenses are reimbursable to family/legal guardian for recipients under age 21 for expanded services. This covers meals and commercial lodging at $25/day for inpatient and $50/day for outpatient.

Medicaid chooses the appropriate transportation based on expense and reasonable availability. May include: public transit, private automobile, taxi, bus, shuttle service, & airline.

Table 55. Administrative Transportation Summary

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Expenditures	$77,953	$130,495	$191,305	$158,432	$133,191
Recipients	272	359	410	412	297
Expenditures per Recipient	$287	$363	$467	$385	$448

PATIENT-CENTERED MEDICAL HOME (PCMH)

The PCMH program promotes high-value care using a value-based purchasing model in which health care is coordinated through a primary care physician/practitioner, with a focus on quality and safety. Participating providers are paid a per member per month rate based on their patient volume.

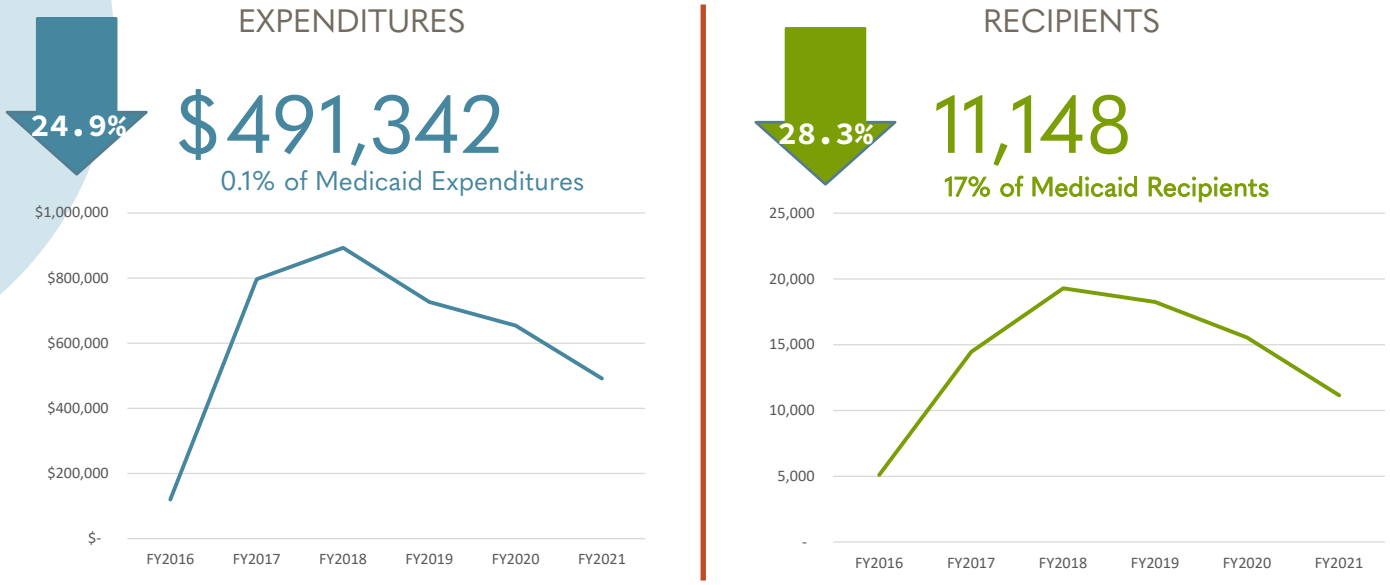


Table 56. Patient-Centered Medical Home Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Expenditures	$119,777	$796,389	$892,709	$726,782	$654,167	$491,342
Recipients	5,102	14,458	19,292	18,247	15,540	11,148
Expenditures per Recipient	$23	$55	$46	$40	$42	$42
Participating Practices	7	13	19	20	12	10
Practitioners in Participating Practices	41	130	168	167	107	114

PROJECT OUT

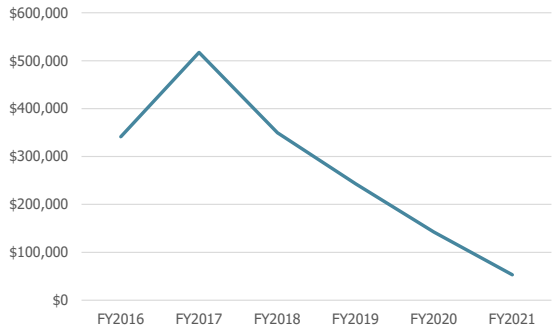
A temporary, short-term intervention and assistance program aimed at helping participants overcome barriers to living independently in the community through diversion or transition. Limited financial resources may be provided to cover the expense of moving/storage, rental/utility deposits, furniture, household items, home modifications, and limited transportation. Participants are also linked to community services and long-term care programs that provide ongoing support. Project Out provides targeted case management to create a transition/diversion plan, identifying the services and supports necessary for independent living.

EXPENDITURES

62.8%

$52,946

.01% of Medicaid Expenditures



RECIPIENTS

71.7%

73

0.1% of Medicaid Recipients

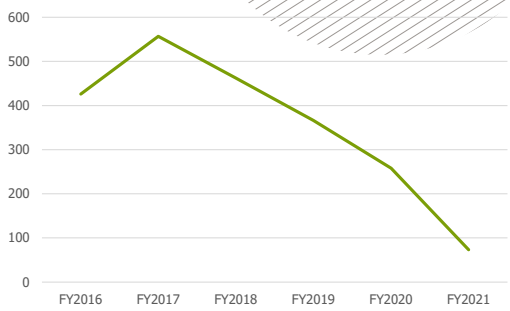


Table 57. Project Out Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Expenditures	$342,198	$517,182	$349,696	$242,854	$142,229	$52,946	-84
Recipients	426	557	462	366	258	73	-83
Expenditures per Recipient	$801	$929	$7576	$664	$551	$725	-9

HEALTH CHECK

This program provides the following services for children under the age of 21 under authority of Early Periodic Screening Detection and Treatment (EPSDT). Medicaid reimburses all Health Check screening exams and authorized follow-up care and treatment as long as the child is enrolled in Medicaid.

- Physical exams
- Immunizations
- Lab tests
- Growth/development check
- Nutrition check
- Vision/Hearing/Dental screenings
- Behavioral health assessment
- Health information
- Teen health education
- Transportation (ambulance & administrative)
- Other healthcare prescribed by a physician and approved by Medicaid

SPECIAL POPULATIONS

The majority of ESRD recipients are dual individuals, those enrolled in both Medicare and Medicaid. Medicare is the primary payer for End-Stage Renal Disease (ESRD) services for dual individuals, and therefore most Medicaid ESRD expenditures are for Medicaid-only individuals.

MEDICAID/MEDICARE DUAL ENROLLED

Individuals with Medicare coverage may also be eligible for Medicaid services, dependent on income. These individuals are referred to as dual enrolled. For these members, Medicare pays first for services covered by both programs, while Medicaid covers additional payments through crossover claims. Non-Medicare-covered services are entirely funded by Medicaid, up to Wyoming's payment limit. This section includes information on both crossover claims services and those services funded entirely by Medicaid. Premium assistance for QMB, SLMB, and QI enrollees is excluded, as these are considered administrative costs.

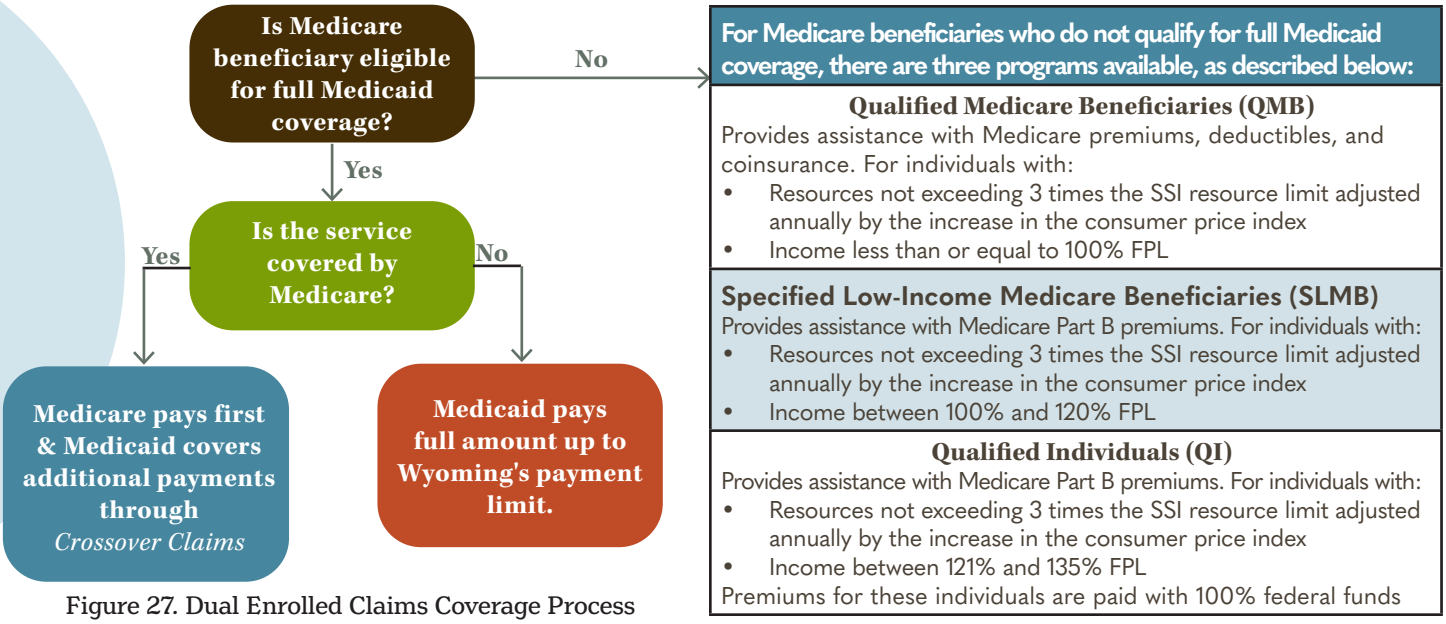


Figure 27. Dual Enrolled Claims Coverage Process

Table 58. Medicaid/Medicare Dual Enrollment Summary

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Dual Enrolled Members	12,679	12,941	13,134	13,294	13,122	12,986	2
Expenditures	$211,425,574	$214,084,240	$206,714,017	$205,433,136	$216,965,992	$209,184,206	-1
Recipients (unduplicated)	10,521	10,927	11,167	11,301	11,706	10,756	2
Expenditures per Recipient	$20,096	$19,592	$18,511	$18,178	$18,534	$19,448	-3
Crossover Claims Expenditures	$17,456,000	$14,824,362	$7,707,733	$7,964,090	$7,948,118	$7,403,458	-58
Crossover Claims Expenditures as Percent of Total Dual Expenditures	8%	7%	4%	4%	4%	4%	-57

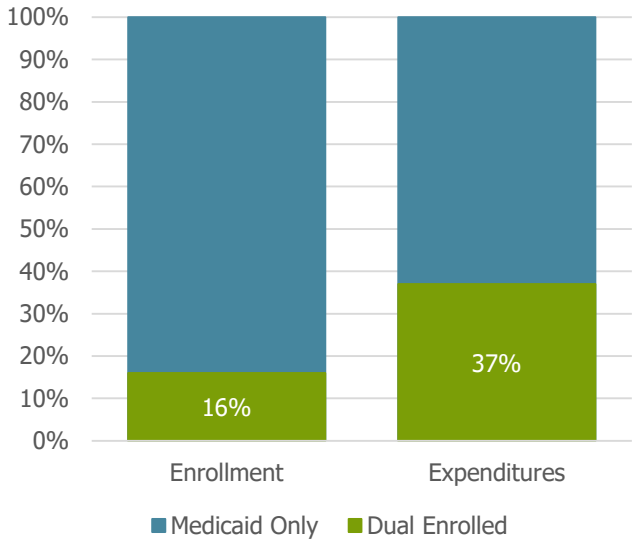


Figure 28. Dual Enrolled as Percent of Total Medicaid in SFY 2021

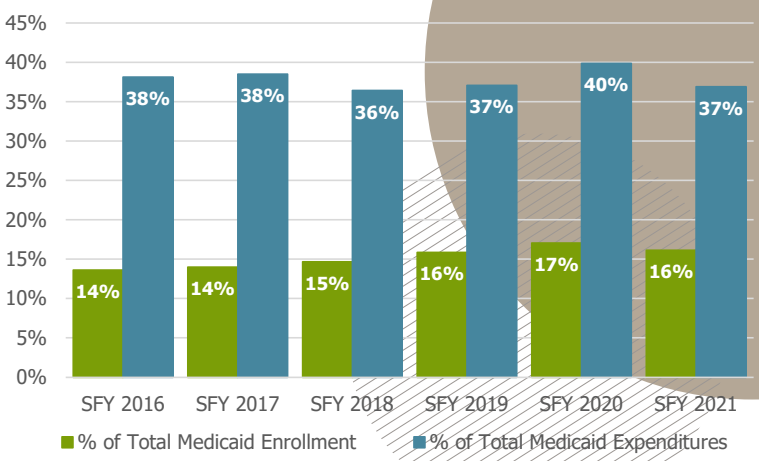


Figure 29. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

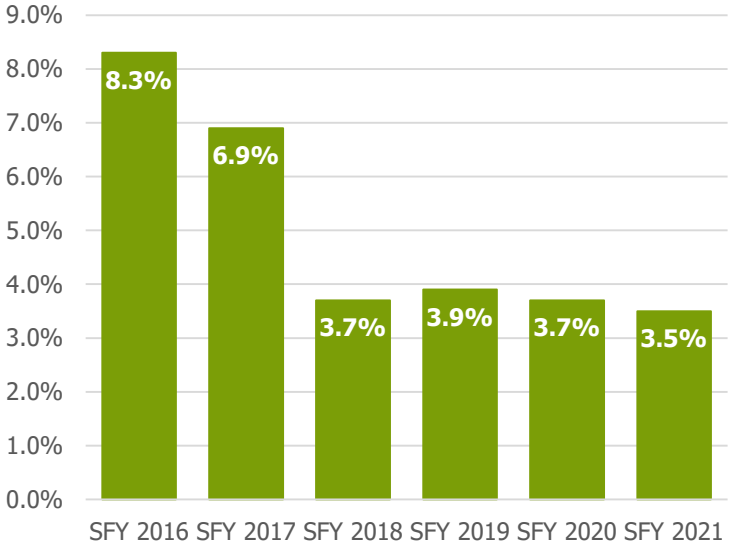


Figure 30. History of Crossover Expenditures as Percent of Total Dual Expenditures

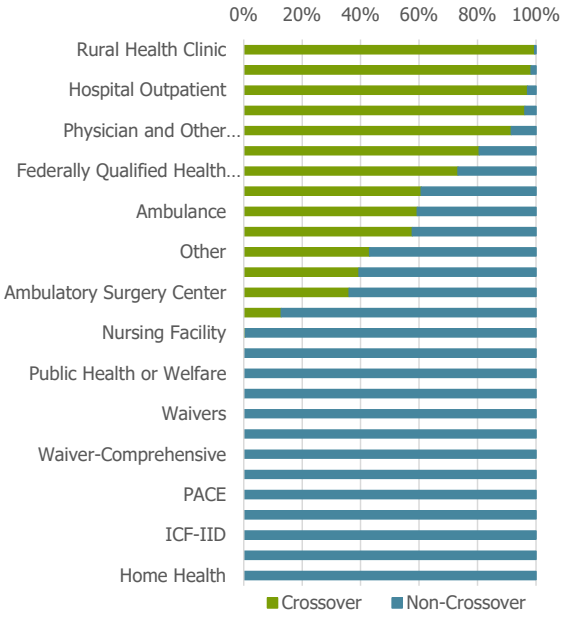


Figure 31. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2021

Claims data for dual-enrolled members was included in the service area detail provided earlier in this report.

Table 59. Dual-Enrolled Member Service Utilization Summary

Service Area	Expenditures	Recipients[38]	Expenditures per Recipient	Crossover Expenditures	Crossover Recipients	Crossover Expenditures per Recipient
Ambulance	$27,075	1,351	$120	$16,086	1,335	$12
Ambulatory Surgical Center	$101,744	280	$363	$36,729	255	$144
Behavioral Health	$1,230,941	1,949	$632	$158,035	1,408	$112
Care Management Entity	--	--	--		--	---
Dental	$442,767	1,702	$260	$32	2	$16
DME, Prosthetics/Orthotics/ Supplies	$2,862,729	3,785	$756	$1,129,617	3,324	$340
End-Stage Renal Disease	$241,248	114	$2,116	$245,346	112	$2,191
Federally Qualified Health Center	$214,500	1,338	$160	$157,336	1,255	$125
Home Health	$56,939	30	$1,898	---	1	$0
Hospice	$909,037	126	$7,215	--	53	$0
Hospital Total	$2,356,383	9,272	$254	$1,894,306	9,174	$206
Inpatient	$1,084,678	2,092	$518	$659,299	2,054	$321
Outpatient	$1,271,705	7,180	$177	$1,235,008	7,120	$173
Intermediate Care Facility-IID	$15,216,914	47	$323,764	---	---	---
Laboratory	$10,736	1,664	$6	$8,657	1,648	$5
Nursing Facility	$73,884,274	2,196	$33,645	$412,435	1,069	$386
Other	$58,376	382	$153	$25,174	245	$103
PACE	$2,059,435	140	$14,710	---	---	---
Physician & Other Practitioner	$3,394,339	8,833	$384	$3,107,104	8,753	$355
Prescription Drug	$709,964	1,527	$465	---	---	---
Public Health or Welfare	$426,192	3,216	$133	$104	195	$1
Public Health, Federal	$389,027	169	$2,302	$1,504	59	$25
Rural Health Clinic	$120,067	1,182	$102	$119,618	1,181	$101
Vision	$77,425	1,990	$39	$74,466	1,967	$38
Waiver Total	$104,364,784	3,846	$27,136	---	---	---
Community Choices	$28,802,052	2,540	$11,339	---	---	---
Comprehensive	$72,788,133	1,100	$66,171	---	---	---
Supports	$2,774,599	206	$13,469	---	---	---
Total	**$209,184,206**	**10,756**	**$19.448**	**$7,403,458**	**9,700**	**$763**

38. This table displays a unique count of recipients for each service area, as well as the total unique count of all dual enrolled recipients. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.

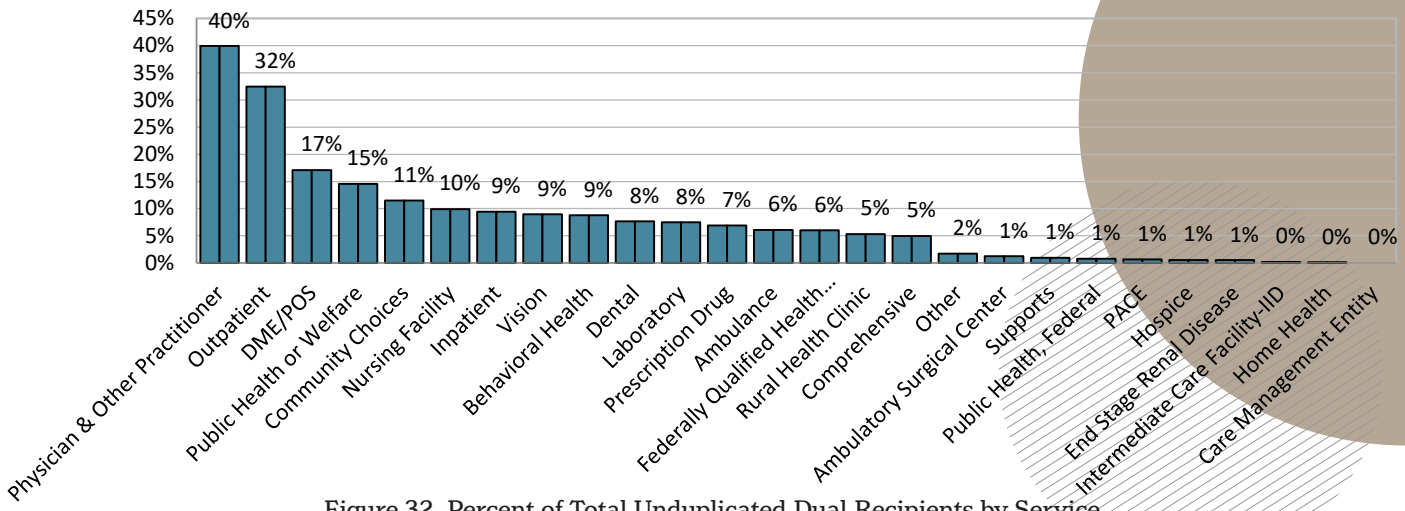


Figure 32. Percent of Total Unduplicated Dual Recipients by Service

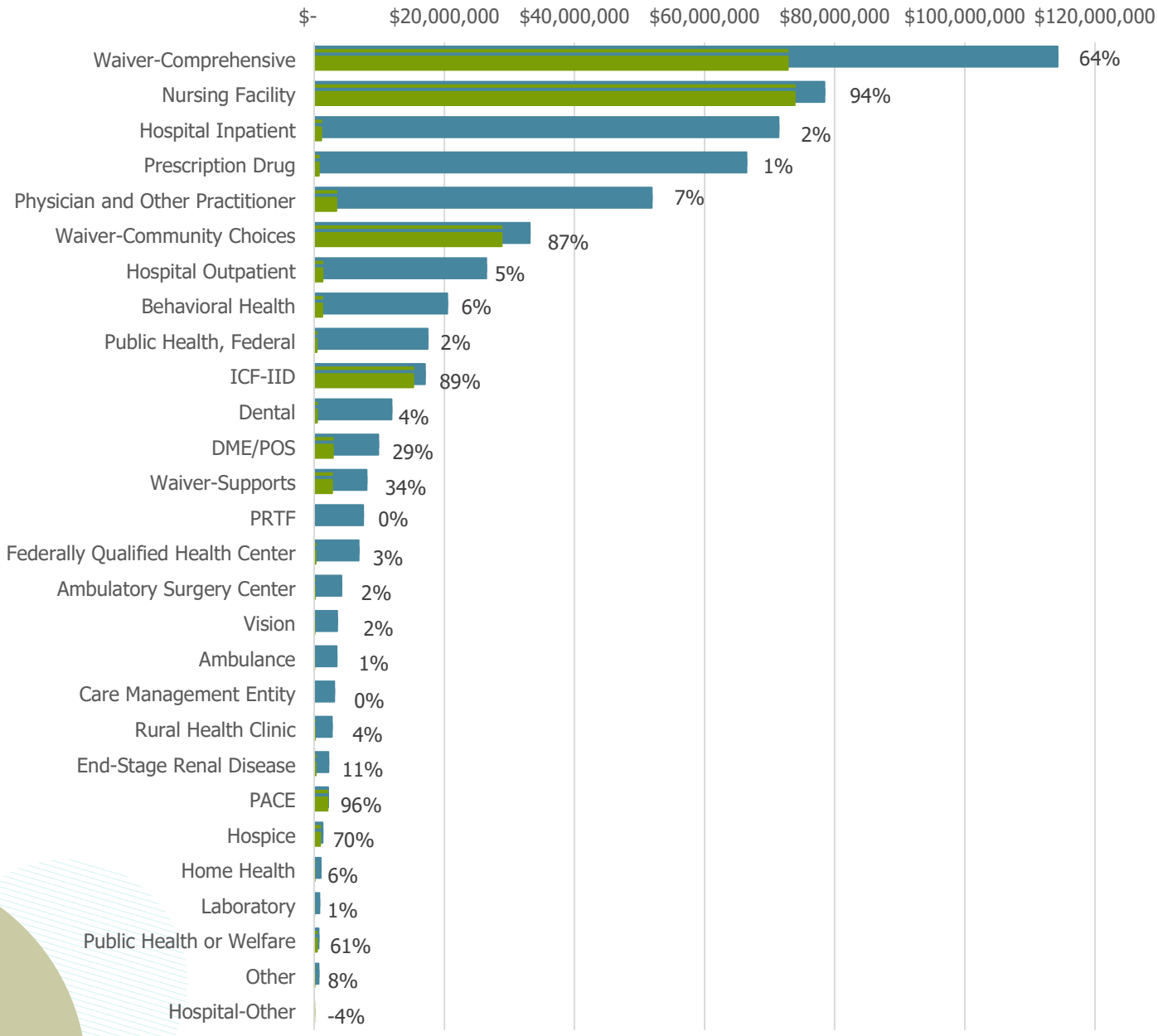


Figure 33. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

FOSTER CARE

The foster care program is administered through the Department of Family Services (DFS), providing for a child until a more permanent plan for the child's well-being can be implemented. Medical coverage under foster care is intended to provide for the medical needs of the children while in DFS custody. Two types of medical coverage are available:

Medicaid Foster Care

For children eligible for Medicaid. Foster children covered under Title IV-E of the Social Security Act and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid. Wyoming also uses existing Medicaid eligibility groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state-funded subsidies.

State Foster Care

For children ineligible for Medicaid. Includes children who do not meet income or citizenship requirements or are institutionalized.

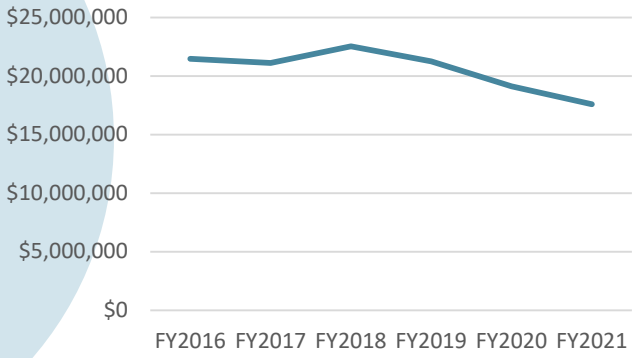
205 children enrolled **$944,427** in claims expenditures

EXPENDITURES

7.9%

$17,599,763

3% of Medicaid Expenditures



RECIPIENTS

11.7%

3,197

5% of Medicaid Recipients

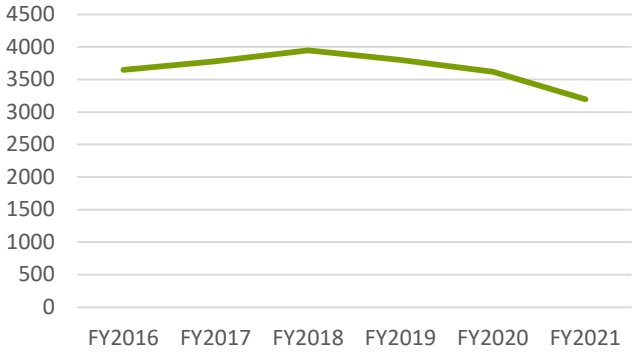


Table 60. Foster Care Summary[39]

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Medicaid Foster Care							
Enrolled Members	4,228	4,102	4,159	3,995	3,881	3,516	-17
Expenditures	$21,473,583	$21,117,610	$22,534,237	$21,259,813	$19,115,700	$17,599,763	-18
Recipients	3,649	3,783	3,946	3,802	3,621	3,197	-12
Expenditures per Recipient	$5,885	$5,582	$5,711	$5,592	$5,279	$5,505	-6
State-Only Foster Care							
Enrolled Members	203	310	316	282	243	204	0.5
Expenditures	$2,281,501	$1,753,782	$1,787,501	$1,736,824	$1,214,600	$944,427	-59
Recipients	321	314	324	322	256	205	-36
Expenditures per Recipient	$7,107	$5,585	$5,517	$5,394	$4,745	$4,607	-35

39. As claims data shown is based on paid date, not service date, the number of recipients may exceed the count of enrolled members as individuals may have claims paid up to one year after services are rendered, at which time they may no longer be enrolled in the program.

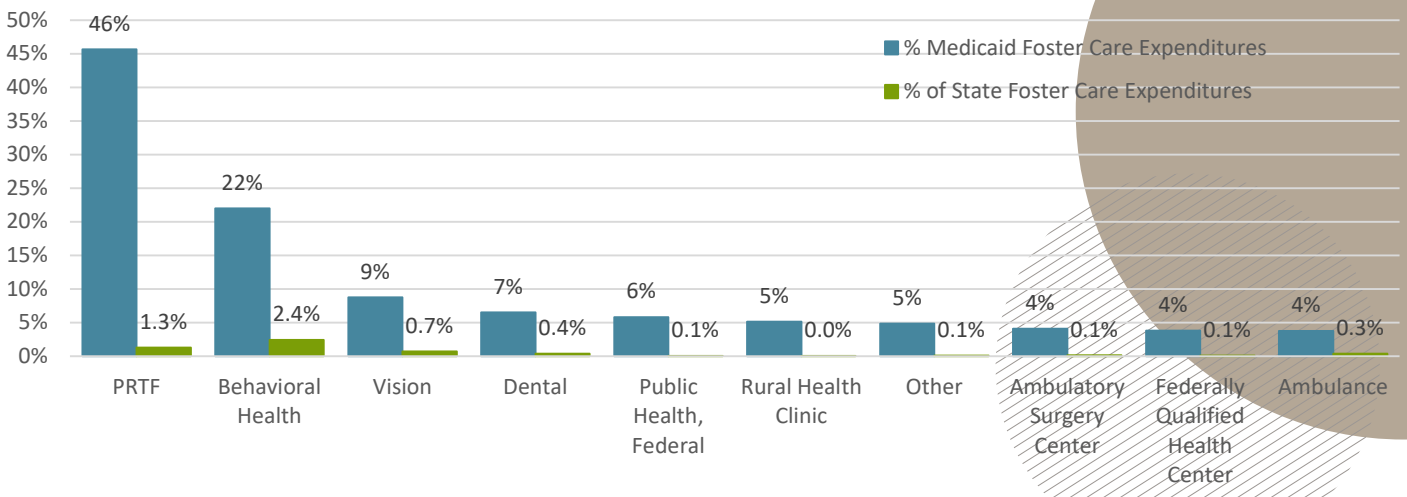


Figure 34. Percent of Foster Care Expenditures by Service - Medicaid versus State-Only

Table 61. Foster Care Summary by Services - Medicaid versus State-Only[40]

	Medicaid Foster Care			State-Only Foster Care		
Service Area	**Expenditures**	**Recipients**	**Expenditures per Recipient**	**Expenditures**	**Recipients**	**Expenditures per Recipient**
Ambulance	$129,683	88	$1,211	$11,919	6	$1,193
Ambulatory Surgical Center	$170,301	102	$1,628	$4,989	4	$2,651
Behavioral Health	$4,500,857	1,409	$3,399	$489,976	165	$3,090
Care Management Entity (CME)	$991	4	$0	--	--	--
Clinic/Center	$114,290	142	$470	--	--	--
Dental	$775,595	1,789	$400	$44,052	109	$397
DME, Prosthetics/Orthotics/ Supplies	$198,023	166	$795	$145	1	$166
Federally Qualified Health Center	$258,513	273	$1,001	$5,695	8	$1,012
Home Health	$1,606	2	$434	--	--	--
Hospital Total	$2,634,455	1329	$1,866	$126,691	87	$901
Inpatient	$1,765,397	164	$7,732	$83,304	9	$6,607
Outpatient	$868,611	1,163	$516	$43,387	78	$421
Laboratory	$24,052	181	$120	$2,309	17	$64
Other	$33,447	165	$204	$706	4	$99
Physician & Other Practitioner	$1,608,414	2,445	$546	$63,702	128	$344
Prescription Drug	$2,247,355	1,743	$1,035	$62,101	142	$594
PRTF	$3,432,617	87	$34,184	$95,047	6	$20,971
Public Health or Welfare	$7,316	137	$63	$2,068	34	$51
Public Health, Federal	$1,014,813	209	$3,651	$9,235	5	$1,730
Rural Health Clinic	$138,867	312	$432	$1,216	4	$264
Vision	$308,568	1,166	$267	$24,578	87	$244
Total	**$17,599,763**	**3,197**	**$5,505**	**$944,427**	**205**	**$4,607**

40. As claims data shown is based on paid date, not service date, the number of recipients may exceed the count of enrolled members as individuals may have claims paid up to one year after services are rendered, at which time they may no longer be enrolled in the program.

APPENDIX A: SUPPLEMENTAL TABLES

SERVICES

Table 62. Behavioral Health Services by Provider Type

Provider	Services Provided
Behavioral Health Providers	
Mental health and substance abuse treatment professionals through Community Mental Health Centers (CMHCs) and Substance Abuse Treatment Centers (SACs)	• Mental health assessments • Individual group therapy • Rehabilitation services • Peer specialists services • Targeted case management
Physicians, including psychiatrists, or other behavioral health practitioners who work under a physician, including: - Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs)) - Physician Assistants	• Medically necessary psychiatric services
Advanced practice mental health nurse practitioners Independently practicing clinical psychologists Mental health practitioners who work under a clinical psychologist Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs))	• Behavioral health services
Non-Behavioral Health Providers	
Psychiatric Residential Treatment Facility	• Psychiatric residential treatment for individuals under age 21
Wyoming State Hospital	• Admits patients considered to be a danger to themselves or others pursuant to Wyoming Statue on involuntary hospitalization • Patients who are psychiatrically and medically fragile • Persons whom the legal system placed in the hospital after classifying them as not competent to stand trial or who were found guilty of committing crimes due to mental illness
Stand-alone Inpatient Psychiatric Hospital	• Behavioral health services

Table 63. Waiver Services by Waiver

Waiver Service	Comprehensive	Supports	Community Choices	Children's Mental Health
Case Management	✓	✓	✓	✓
Functional assessments	✓	✓	✓	✓
Respite	✓	✓	✓	✓
Personal care	✓	✓	✓	
Skilled nursing	✓	✓	✓	
Dietitian	✓	✓	✓*	
Homemaker	✓	✓	✓	
Special family habilitation home	✓			
Day habilitation	✓	✓		
Child habilitation	✓	✓		
Residential habilitation training	✓	✓		
Specialized equipment	✓	✓		
Environmental modifications	✓	✓		
Supported living	✓	✓		
Community integrated employment	✓	✓		
Employment supports	✓	✓		
Companion	✓	✓		
Occupational, physical, and Speech therapies	✓	✓		
Cognitive retraining				
Self-directed / Consumer-directed available	✓	✓	✓	
High Fidelity Wraparound				✓
Family and Youth Peer Support Services				✓

BIRTHS

Table 64. Wyoming Medicaid Births[41]

Calendar Year	Wyoming Births	Medicaid Births	Medicaid % of Total
2008	8,015	3,353	42%
2009	7,841	3,401	43%
2010	7,541	3,395	45%
2011	7,339	3,166	43%
2012	7,576	3,071	41%
2013	7,617	3,026	40%
2014	7,693	2,850	37%
2015	7,715	2,757	36%
2016	7,384	2,704	37%
2017	6,904	2,439	35%
2018	6,549	2,206	34%
2019	6,566	2,148	33%
2020	6,133	1,993	32%

41. Provisional statistics for statewide births were supplied by Vital Records.

COUNTY DATA

Table 65. County Summary

County	Enrolled Members[42]	% of Total Enrolled Members	Recipients[43]	% of Total Recipients	Expenditures	% of Total Expenditures
Albany	3,278	4%	2,940	4%	$22,799,742.32	4%
Big Horn	1,944	3%	1,701	3%	$14,383,133.87	3%
Campbell	5,914	8%	5,368	8%	$34,046,512.69	6%
Carbon	1,761	2%	1,546	2%	$9,088,166.98	2%
Converse	1,772	2%	1,545	2%	$11,094,329.29	2%
Crook	789	1%	713	1%	$3,874,223.34	1%
Fremont	9,064	12%	8,438	13%	$105,704,126.24	19%
Goshen	1,671	2%	1,489	2%	$12,774,013.90	2%
Hot Springs	740	1%	644	1%	$6,723,395.95	1%
Johnson	881	1%	752	1%	$5,544,244.35	1%
Laramie	12,701	17%	1,1357	17%	$95,267,145.74	17%
Lincoln	1,628	2%	1,370	2%	$10,619,300.67	2%
Natrona	12,100	16%	11,090	17%	$90,849,304.02	16%
Niobrara	312	0%	258	0%	$1,692,656.62	0%
Other[42]	1,777	2%	1,357	2%	$10,467,102.12	2%
Park	3,403	5%	2961	4%	$23,271,707.64	4%
Platte	1,117	1%	965	1%	$6,494,048.99	1%
Sheridan	3,610	5%	3,240	5%	$23,845,740.10	4%
Sublette	668	1%	550	1%	$3,016,010.61	1%
Sweetwater	5,501	7%	4,948	7%	$32,688,426.07	6%
Teton	1,013	1%	885	1%	$5,418,777.82	1%
Uinta	3,044	4%	2,762	4%	$24,251,389.98	4%
Washakie	1,082	1%	972	1%	$8,300,817.47	1%
Weston	764	1%	683	1%	$5,478,813.56	1%
Overall	**75,331**		**66,708**		**$566,889,365**	

42. Enrollment is based on Complete SFY.
43. Recipients and Expenditures are based on the recipient county of residence on file at the time the claim was processed in the MMIS. As recipients may move between counties, summing the county totals will not match the total recipient count shown. Recipients in "Other" county have moved out of the state prior to their claim being processed.

PROVIDERS

The data in this section is based on providers paid during the SFY and does not reflect the number of enrolled providers.

Table 66. Provider Summary by Taxonomy - SFY 2021

Provider Taxonomy	Providers	Recipients[44]	Expenditures
Advanced Practice Midwife (367A00000X)	3	18	$16,866
Allergy & Immunology, Allergy (207KA0200X)	6	323	$121,800
Ambulance (341600000X)	67	3,420	$3,441,088
Anesthesiology (207L00000X)	56	6,943	$2,372,652
Audiologist (231H00000X)	13	427	$175,435
Behavior Analyst (103K00000X)	5	72	$1,673,558
Case Management (251B00000X)	129	2,959	$33,151,973
Chiropractor (111N00000X)	55	1,669	$337,670
Clinic/Center (261Q00000X)	11	920	$712,388
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	5	196	$41,326
Clinic/Center, Ambulatory Surgical (261QA1903X)	30	2,714	$4,183,523
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	15	151	$2,172,271
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	15	7,409	$6,839,456
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	27	3,719	$2,961,835
Clinic/Center, Public Health, Federal (261QP0904X)	5	3,934	$17,453,190
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	58	$26,454
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	32	1,179	$2,228,012
Clinic/Center, Rural Health (261QR1300X)	34	5,967	$2,708,379
Clinical Medical Laboratory (291U00000X)	76	7,159	$797,433
Clinical Neuropsychologist (103G00000X)	1	24	$23,900
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	10	897	$275,019
Community/Behavioral Health (251S00000X)	29	494	$3,083,353
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	4	79	$15,045
Counselor, Professional (101YP2500X)	154	2,667	$4,642,838
Day Training, Developmentally Disabled Services (251C00000X)	623	2,702	$115,386,582
Dentist (122300000X)	31	3,466	$1,299,378
Dentist, Endodontics (1223E0200X)	3	93	$64,620
Dentist, General Practice (1223G0001X)	109	10,958	$3,596,275
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	9	1,439	$1,144,135
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	14	351	$283,798
Dentist, Pediatric Dentistry (1223P0221X)	30	13,551	$5,510,329
Dermatology (207N00000X)	16	1,961	$288,837
Dietitian, Registered (133V00000X)	2	2	$385
Durable Medical Equipment & Medical Supplies (332B00000X)	204	7,727	$8,742,496
Emergency Medicine (207P00000X)	32	16,077	$3,446,604
Family Medicine (207Q00000X)	80	18,798	$4,727,108

44. This table displays a unique count of recipients for each provider taxonomy. Summing the recipients across all taxonomies will not equal the total recipients shown as recipients often receive multiple services throughout the SFY.

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
General Acute Care Hospital (282N00000X)	107	29,095	$84,960,939
General Acute Care Hospital, Rural (282NR1301X)	32	8,899	$11,513,676
Hearing Aid Equipment (332S00000X)	9	231	$493,176
Home Health (251E00000X)	20	243	$992,823
Hospice Care, Community Based (251G00000X)	14	181	$1,297,041
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	53	$17,024,561
Internal Medicine (207R00000X)	59	13,943	$7,014,980
Internal Medicine, Cardiovascular Disease (207RC0000X)	17	2,256	$354,478
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	3	151	$20,203
Internal Medicine, Gastroenterology (207RG0100X)	7	1,762	$736,866
Internal Medicine, Geriatric Medicine (207RG0300X)	4	192	$42,598
Internal Medicine, Medical Oncology (207RX0202X)	4	190	$647,946
Internal Medicine, Nephrology (207RN0300X)	6	422	$62,204
Internal Medicine, Pulmonary Disease (207RP1001X)	8	422	$114,401
Internal Medicine, Rheumatology (207RR0500X)	3	177	$18,004
Interpreter (171R00000X)	2	79	$17,094
Lodging (177F00000X)	4	127	$105,625
Marriage & Family Therapist (106H00000X)	12	192	$512,977
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	28	$4,482
Medicare Defined Swing Bed Unit (275N00000X)	13	61	$633,663
Midwife (176B00000X)	3	48	$36,514
Neurological Surgery (207T00000X)	11	577	$3,911,236
Nurse Anesthetist, Certified Registered (367500000X)	12	644	$133,402
Nurse Practitioner (363L00000X)	17	1,504	$330,772
Nurse Practitioner, Adult Health (363LA2200X)	1	18	$1,862
Nurse Practitioner, Family (363LF0000X)	23	1,808	$365,288
Nurse Practitioner, Pediatrics (363LP0200X)	3	132	$19,309
Obstetrics & Gynecology (207V00000X)	27	3,760	$3,708,849
Obstetrics & Gynecology, Gynecology (207VG0400X)	2	190	$97,463
Obstetrics & Gynecology, Obstetrics (207VX0000X)	4	293	$253,688
Occupational Therapist (225X00000X)	14	493	$1,606,782
Ophthalmology (207W00000X)	35	1,966	$652,329
Optometrist (152W00000X)	83	14,861	$3,477,790
Orthopaedic Surgery (207X00000X)	29	4,431	$1,399,881
Otolaryngology (207Y00000X)	15	2,260	$702,197
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	13	1,577	$67,961
Pediatrics (208000000X)	65	11,134	$4,388,597
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	5	238	$332,879
Pharmacy (333600000X)	215	34,276	$66,364,286
Physical Medicine & Rehabilitation (208100000X)	12	339	$157,540
Physical Therapist (225100000X)	75	3,335	$3,032,422
Physician Assistant (363A00000X)	2	105	$38,811

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Physician, General Practice (208D00000X)	58	19,452	$6,999,142
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	5	33	$9,091
Podiatrist (213E00000X)	12	797	$34,640
Private Vehicle (347C00000X)	2	23	$8,702
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	1	143	$2,152,985
Prosthetic/Orthotic Supplier (335E00000X)	27	547	$610,680
Psychiatric Hospital (283Q00000X)	3	14	$75,743
Psychiatric Residential Treatment Facility (323P00000X)	14	202	$7,517,488
Psychiatry & Neurology, Neurology (2084N0400X)	19	1,554	$324,947
Psychiatry & Neurology, Psychiatry (2084P0800X)	20	944	$1,855,312
Psychologist, Clinical (103TC0700X)	53	2,640	$3,590,637
Public Health or Welfare (251K00000X)	25	6,242	$694,400
Radiology, Diagnostic Radiology (2085R0202X)	41	17,672	$1,874,163
Rehabilitation Hospital (283X00000X)	3	126	$567,445
Skilled Nursing Facility (314000000X)	48	2,282	$77,813,463
Social Worker, Clinical (1041C0700X)	96	2,064	$2,690,806
Specialist (174400000X)	3	360	$56,864
Speech-Language Pathologist (235Z00000X)	13	286	$370,827
Supports Brokerage (251X00000X)	1	474	$6,977,663
Surgery (208600000X)	32	1,659	$588,358
Surgery, Pediatric Surgery (2086S0120X)	5	81	$50,641
Surgery, Vascular Surgery (2086S0129X)	4	53	$14,120
Taxi (344600000X)	2	147	$18,864
Technician/Technologist, Optician (156FX1800X)	5	398	$48,565
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	1	14	$8,685
Unclassified	1	70	$89,626
Urology (208800000X)	10	1,173	$251,901
Total	**3,432**	**66,708**	**$566,889,365**

Table 67. Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Services (251C00000X)	$115,386,582	20%
General Acute Care Hospital (282N00000X)	$84,960,939	15%
Skilled Nursing Facility (314000000X)	$77,813,463	14%
Pharmacy (333600000X)	$66,364,286	12%
Case Management (251B00000X)	$33,151,973	6%
Clinic/Center, Public Health, Federal (261QP0904X)	$17,453,190	3%
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$17,024,561	3%
General Acute Care Hospital, Rural (282NR1301X)	$11,513,676	2%
Durable Medical Equipment & Medical Supplies (332B00000X)	$8,742,496	2%
Psychiatric Residential Treatment Facility (323P00000X)	$7,517,488	1%
Internal Medicine (207R00000X)	$7,014,980	1%
Physician, General Practice (208D00000X)	$6,999,142	1%
Supports Brokerage (251X00000X)	$6,977,663	1%
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$6,839,456	1%
Dentist, Pediatric Dentistry (1223P0221X)	$5,510,329	1%
Family Medicine (207Q00000X)	$4,727,108	1%
Counselor, Professional (101YP2500X)	$4,642,838	1%
Pediatrics (208000000X)	$4,388,597	1%
Clinic/Center, Ambulatory Surgical (261QA1903X)	$4,183,523	1%
Neurological Surgery (207T00000X)	$3,911,236	1%
Total for Top 20 Providers	**$495,123,527**	**87%**

Table 68. Provider Count History by Taxonomy

Provider Taxonomy	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Advanced Practice Midwife (367A00000X)	9	7	8	4	4	3	-67%
Allergy & Immunology, Allergy (207KA0200X)	9	6	5	5	5	6	-33%
Ambulance (341600000X)	68	64	63	73	66	67	-1%
Anesthesiology (207L00000X)	87	73	78	73	56	56	-36%
Audiologist (231H00000X)	15	14	12	13	12	13	-13%
Behavior Analyst (103K00000X)			5	3	7	5	--
Case Management (251B00000X)	101	115	114	120	128	129	28%
Chiropractor (111N00000X)	34	50	52	54	54	55	62%
Clinic/Center (261Q00000X)	12	14	23	12	12	11	-8%
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	9	9	7	7	5	5	-44%
Clinic/Center, Ambulatory Surgical (261QA1903X)	33	28	28	31	27	30	-9%
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	14	15	15	16	15	15	7%
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	9	12	11	11	16	15	67%

Provider Taxonomy (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	27	27	26	26	27	27	--
Clinic/Center, Public Health, Federal (261QP0904X)	4	4	4	5	4	5	25%
Clinic/Center, Radiology, Mobile (261QR0208X)	2				1		-100%
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1	--
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	32	31	32	33	33	32	--
Clinic/Center, Rural Health (261QR1300X)	23	21	24	32	31	34	48%
Clinical Medical Laboratory (291U00000X)	90	85	74	71	70	76	-16%
Clinical Neuropsychologist (103G00000X)	2	2	4	4	5	1	-50%
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	12	14	12	9	10	10	-17%
Community/Behavioral Health (251S00000X)	1	1	1	1	1	29	2800%
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	4	4	3	3	3	4	--
Counselor, Professional (101YP2500X)	97	123	138	145	155	154	59%
Day Training, Developmentally Disabled Services (251C00000X)	614	629	649	656	659	623	1%
Dentist (122300000X)	28	29	27	29	31	31	11%
Dentist, Endodontics (1223E0200X)	5	3	3	2	4	3	-40%
Dentist, General Practice (1223G0001X)	149	137	130	129	121	109	-27%
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	14	16	11	13	11	9	-36%
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	16	17	15	17	14	14	-13%
Dentist, Pediatric Dentistry (1223P0221X)	34	32	34	32	33	30	-12%
Dentist, Periodontics (1223P0300X)	1						--
Dermatology (207N00000X)	15	13	15	17	16	16	7%
Dietitian, Registered (133V00000X)		1	2	2	2	2	--
Durable Medical Equipment & Medical Supplies (332B00000X)	246	234	231	222	202	204	-17%
Emergency Medicine (207P00000X)	39	36	32	32	29	32	-18%
Family Medicine (207Q00000X)	88	86	84	93	86	80	-9%
General Acute Care Hospital (282N00000X)	190	114	114	112	103	107	-44%
General Acute Care Hospital, Rural (282NR1301X)	42	36	30	27	26	32	-24%
Hearing Aid Equipment (332S00000X)	12	11	9	8	9	9	-25%
Home Health (251E00000X)	30	29	25	23	23	20	-33%
Hospice Care, Community Based (251G00000X)	11	12	13	12	13	14	27%
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	1	1	1	1	1	--
Internal Medicine (207R00000X)	68	55	57	60	57	59	-13%

Provider Taxonomy (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	8	4	4	4	4	3	-63%
Internal Medicine, Gastroenterology (207RG0100X)	9	4	6	6	6	7	-22%
Internal Medicine, Geriatric Medicine (207RG0300X)	2	4	4	5	5	4	--
Internal Medicine, Medical Oncology (207RX0202X)	11	7	6	4	4	4	-64%
Internal Medicine, Nephrology (207RN0300X)	9	6	6	7	6	6	-33%
Internal Medicine, Pulmonary Disease (207RP1001X)	12	11	9	10	8	8	-33%
Internal Medicine, Rheumatology (207RR0500X)	4	2	2	2	2	3	-25%
Interpreter (171R00000X)	1	1	2	3	2	2	100%
Lodging (177F00000X)		2	3	2	2	4	--
Marriage & Family Therapist (106H00000X)	10	15	13	15	10	12	20%
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)		1	1	1	1	1	--
Medicare Defined Swing Bed Unit (275N00000X)	10	11	15	11	12	13	30%
Midwife (176B00000X)					3	3	--
Neurological Surgery (207T00000X)	16	12	10	10	9	11	-31%
Nurse Anesthetist, Certified Registered (367500000X)	21	16	13	14	13	12	-43%
Nurse Practitioner (363L00000X)	10	9	9	14	14	17	70%
Nurse Practitioner, Adult Health (363LA2200X)	1	1	1	1	1	1	--
Nurse Practitioner, Family (363LF0000X)	16	15	12	16	23	23	44%
Nurse Practitioner, Obstetrics & Gynecology (363LX0001X)	1						--
Nurse Practitioner, Pediatrics (363LP0200X)	2	2	2	2	3	3	50%
Obstetrics & Gynecology (207V00000X)	48	40	33	28	27	27	-44%
Obstetrics & Gynecology, Gynecology (207VG0400X)	6	5	5	3	4	2	-67%
Obstetrics & Gynecology, Obstetrics (207VX0000X)	5	5	5	5	4	4	-20%
Occupational Therapist (225X00000X)	20	21	20	17	14	14	-30%
Ophthalmology (207W00000X)	34	25	30	32	32	35	3%
Optometrist (152W00000X)	98	93	89	80	77	83	-15%
Orthopaedic Surgery (207X00000X)	37	36	34	32	30	29	-22%
Otolaryngology (207Y00000X)	27	24	19	18	15	15	-44%
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	22	19	17	16	14	13	-41%
Pediatrics (208000000X)	73	97	76	67	69	65	-11%
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	6	5	5	3	4	5	-17%

Provider Taxonomy (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Pharmacy (333600000X)	207	205	208	206	205	215	4%
Physical Medicine & Rehabilitation (208100000X)	17	14	12	15	14	12	-29%
Physical Therapist (225100000X)	60	63	62	67	66	75	25%
Physician Assistant (363A00000X)	1	1	1	3	5	2	100%
Physician, General Practice (208D00000X)	81	67	62	58	61	58	-28%
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	10	11	11	7	8	5	-50%
Podiatrist (213E00000X)	16	13	11	15	14	12	-25%
Private Vehicle (347C00000X)		4	4	6	3	2	--
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	1	1	1	1	1	1	--
Prosthetic/Orthotic Supplier (335E00000X)	27	26	31	28	28	27	--
Psychiatric Hospital (283Q00000X)	2	3	3	3	4	3	50%
Psychiatric Residential Treatment Facility (323P00000X)	17	14	13	16	13	14	-18%
Psychiatry & Neurology, Neurology (2084N0400X)	26	20	19	22	21	19	-27%
Psychiatry & Neurology, Psychiatry (2084P0800X)	32	31	26	25	21	20	-38%
Psychologist, Clinical (103TC0700X)	96	76	69	60	59	53	-45%
Public Health or Welfare (251K00000X)	24	24	24	24	24	25	4%
Radiology, Diagnostic Radiology (2085R0202X)	45	46	49	46	44	41	-9%
Rehabilitation Hospital (283X00000X)	3	2	3	3	2	3	--
Residential Treatment Facility, Emotionally Disturbed Children (322D00000X)	3						--
Skilled Nursing Facility (314000000X)	53	53	52	56	56	48	-9%
Social Worker, Clinical (1041C0700X)	60	74	77	84	94	96	60%
Specialist (174400000X)			7	7	4	3	--
Speech-Language Pathologist (235Z00000X)	10	9	9	10	10	13	30%
Supports Brokerage (251X00000X)	1	2	1	1	1	1	--
Surgery (208600000X)	43	33	30	30	31	32	-26%
Surgery, Pediatric Surgery (2086S0120X)	3	5	2	2	5	5	67%
Surgery, Vascular Surgery (2086S0129X)	6	4	4	5	4	4	-33%
Taxi (344600000X)		1	1	1	1	2	--
Technician, Pathology, Phlebotomy (246RP1900X)	1						--
Technician/Technologist, Optician (156FX1800X)	9	6	6	6	6	5	-44%
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	5	3	2	2	2	1	-80%
Unclassified	1	1	1	1	1	1	--
Urology (208800000X)	17	16	13	13	12	10	-41%
Total	**3,720**	**3,549**	**3,505**	**3,509**	**3,446**	**3,432**	**-8**

Eligibility Category	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Advanced Practice Midwife (367A00000X)	$51,381	$89,855	$64,608	$31,747	$27,464	$16,866	-67%
Allergy & Immunology, Allergy (207KA0200X)	$444,553	$372,655	$396,665	$282,684	$210,462	$121,800	-73%
Ambulance (341600000X)	$3,571,623	$3,847,375	$2,381,969	$3,543,958	$2,869,734	$3,441,088	-4%
Anesthesiology (207L00000X)	$2,568,307	$2,697,539	$2,488,633	$2,449,632	$2,387,211	$2,372,652	-8%
Audiologist (231H00000X)	$123,718	$158,494	$229,847	$141,981	$344,821	$175,435	42%
Behavior Analyst (103K00000X)			$167,595	$533,209	$831,883	$1,673,558	--
Case Management (251B00000X)	$20,056,159	$21,007,543	$27,226,271	$29,146,077	$29,686,195	$33,151,973	65%
Chiropractor (111N00000X)	$99,664	$280,207	$347,441	$406,862	$368,608	$337,670	239%
Clinic/Center (261Q00000X)	$1,361,953	$1,327,800	$972,701	$815,334	$435,776	$712,388	-48%
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	$55,497	$62,853	$51,449	$51,977	$48,668	$41,326	-26%
Clinic/Center, Ambulatory Surgical (261QA1903X)	$5,953,159	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	-30%
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	$948,612	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	129%
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$3,689,548	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	85%
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	$7,930,515	$7,681,061	$6,195,978	$5,381,311	$3,950,814	$2,961,835	-63%
Clinic/Center, Public Health, Federal (261QP0904X)	$8,479,944	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	106%
Clinic/Center, Radiology, Mobile (261QR0208X)	$7				$0		--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$146,226	$84,406	$29,156	$26,024	$22,394	$26,454	-82%
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	$3,895,890	$2,997,914	$2,939,968	$2,793,311	$3,065,233	$2,228,012	-43%
Clinic/Center, Rural Health (261QR1300X)	$1,413,842	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	92%
Clinical Medical Laboratory (291U00000X)	$1,536,310	$844,218	$1,020,356	$719,701	$585,977	$797,433	-48%
Clinical Neuropsychologist (103G00000X)	$642	$8,924	$78,578	$50,843	$37,580	$23,900	3622%
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	$286,789	$335,697	$363,266	$326,066	$278,963	$275,019	-4%
Community/Behavioral Health (251S00000X)	$5,021,978	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353	-39%
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	$112,463	$235,019	$207,018	$210,373	$62,187	$15,045	-87%
Counselor, Professional (101YP2500X)	$2,338,814	$3,676,332	$5,605,555	$5,024,798	$4,176,857	$4,184,775	79

Eligibility Category (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Counselor, Professional (101YP2500X)	$3,676,332	$5,605,555	$5,024,798	$4,176,857	$4,184,775	$4,642,838	26%
Day Training, Developmentally Disabled Services (251C00000X)	$93,766,911	$95,950,535	$100,791,096	$113,656,959	$114,351,936	$115,386,582	23%
Dentist (122300000X)	$1,445,036	$1,468,732	$1,051,336	$962,164	$867,521	$1,299,378	-10%
Dentist, Endodontics (1223E0200X)	$51,569	$43,105	$52,582	$49,611	$52,182	$64,620	25%
Dentist, General Practice (1223G0001X)	$7,171,071	$6,085,423	$4,331,962	$3,985,182	$3,089,844	$3,596,275	-50%
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	$1,225,956	$1,132,105	$1,106,227	$879,442	$873,145	$1,144,135	-7%
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	$547,443	$543,829	$368,831	$420,012	$261,832	$283,798	-48%
Dentist, Pediatric Dentistry (1223P0221X)	$5,008,474	$4,894,424	$4,936,642	$5,007,670	$4,749,104	$5,510,329	10%
Dentist, Periodontics (1223P0300X)	$480						--
Dermatology (207N00000X)	$253,755	$272,569	$300,262	$271,678	$254,356	$288,837	14%
Dietitian, Registered (133V00000X)		$391	$1,803	$617	$697	$385	--
Durable Medical Equipment & Medical Supplies (332B00000X)	$6,610,828	$7,360,167	$6,944,732	$7,850,643	$8,174,435	$8,742,496	32%
Emergency Medicine (207P00000X)	$3,198,766	$4,130,517	$4,026,740	$3,855,001	$3,400,286	$3,446,604	8%
Family Medicine (207Q00000X)	$6,384,974	$6,805,220	$6,424,856	$5,746,636	$5,163,045	$4,727,108	-26%
General Acute Care Hospital (282N00000X)	$91,167,750	$83,353,763	$84,380,731	$84,697,383	$75,855,320	$84,960,939	-7%
General Acute Care Hospital, Rural (282NR1301X)	$15,380,672	$14,474,403	$11,942,563	$12,195,829	$11,589,064	$11,513,676	-25%
Hearing Aid Equipment (332S00000X)	$790,555	$912,176	$831,358	$567,915	$775,873	$493,176	-38%
Home Health (251E00000X)	$9,467,835	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	-90%
Hospice Care, Community Based (251G00000X)	$1,014,959	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	28%
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$18,193,221	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	-6%
Internal Medicine (207R00000X)	$6,899,612	$7,938,991	$7,076,336	$7,075,072	$6,517,068	$7,014,980	2%
Internal Medicine, Cardiovascular Disease (207RC0000X)	$388,767	$419,095	$291,341	$302,157	$326,970	$354,478	-9%
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	$19,270	$22,999	$18,807	$21,509	$23,002	$20,203	5%
Internal Medicine, Gastroenterology (207RG0100X)	$442,390	$495,528	$550,096	$479,940	$423,968	$736,866	67%
Internal Medicine, Geriatric Medicine (207RG0300X)	$20,590	$27,816	$12,796	$43,908	$43,886	$42,598	107%
Internal Medicine, Medical Oncology (207RX0202X)	$1,632,500	$2,469,020	$2,756,577	$1,914,670	$2,155,922	$647,946	-60%
Internal Medicine, Nephrology (207RN0300X)	$51,808	$26,828	$37,495	$64,890	$73,053	$62,204	20%

Eligibility Category (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Internal Medicine, Pulmonary Disease (207RP1001X)	$77,414	$147,096	$102,784	$121,574	$91,720	$114,401	48%
Internal Medicine, Rheumatology (207RR0500X)	$15,778	$18,310	$13,849	$13,841	$8,389	$18,004	14%
Interpreter (171R00000X)	$47,205	$32,056	$22,119	$5,799	$9,096	$17,094	-64%
Lodging (177F00000X)		$53,950	$85,915	$127,715	$108,735	$105,625	--
Marriage & Family Therapist (106H00000X)	$280,470	$298,392	$510,758	$391,014	$376,927	$512,977	83%
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)		$2,583	$6,455	$3,266	$3,083	$4,482	--
Medicare Defined Swing Bed Unit (275N00000X)	$775,338	$462,413	$620,073	$479,918	$557,037	$633,663	-18%
Midwife (176B00000X)					$14,782	$36,514	--
Neurological Surgery (207T00000X)	$536,628	$251,854	$69,210	$75,191	$88,516	$3,911,236	629%
Nurse Anesthetist, Certified Registered (367500000X)	$189,955	$73,627	$65,899	$78,819	$86,639	$133,402	-30%
Nurse Practitioner (363L00000X)	$336,366	$297,224	$142,851	$200,823	$277,571	$330,772	-2%
Nurse Practitioner, Adult Health (363LA2200X)	$1,789	$7	$2,582	$2,284	$2,958	$1,862	4%
Nurse Practitioner, Family (363LF0000X)	$311,405	$268,262	$246,169	$251,881	$338,367	$365,288	17%
Nurse Practitioner, Obstetrics & Gynecology (363LX0001X)	$7,023						-100%
Nurse Practitioner, Pediatrics (363LP0200X)	$12,213	$20,832	$20,745	$15,922	$16,328	$19,309	58%
Obstetrics & Gynecology (207V00000X)	$5,733,312	$4,887,444	$4,563,484	$3,814,652	$3,657,589	$3,708,849	-35%
Obstetrics & Gynecology, Gynecology (207VG0400X)	$80,997	$164,003	$134,985	$93,676	$94,634	$97,463	20%
Obstetrics & Gynecology, Obstetrics (207VX0000X)	$417,994	$655,371	$534,587	$503,347	$474,269	$253,688	-39%
Occupational Therapist (225X00000X)	$3,053,289	$3,199,864	$2,904,323	$1,884,711	$1,630,049	$1,606,782	-47%
Ophthalmology (207W00000X)	$606,722	$604,685	$584,656	$574,291	$542,002	$652,329	8%
Optometrist (152W00000X)	$3,571,953	$3,782,521	$3,656,808	$3,409,020	$2,930,037	$3,477,790	-3%
Orthopaedic Surgery (207X00000X)	$1,404,323	$1,628,003	$1,534,594	$1,222,153	$1,344,579	$1,399,881	--
Otolaryngology (207Y00000X)	$895,930	$917,671	$795,300	$679,438	$523,531	$702,197	-22%
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	$164,404	$145,815	$142,709	$83,620	$80,615	$67,961	-59%
Pediatrics (208000000X)	$5,455,184	$5,310,575	$4,878,853	$4,681,066	$3,931,381	$4,388,597	-20%
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$248,989	$227,825	$295,963	$208,703	$283,124	$332,879	34%
Pharmacy (333600000X)	$48,325,155	$50,007,275	$57,006,524	$61,385,109	$60,432,330	$66,364,286	37%
Physical Medicine & Rehabilitation (208100000X)	$128,026	$111,247	$119,039	$137,136	$123,650	$157,540	23%
Physical Therapist (225100000X)	$3,382,286	$3,286,973	$2,653,095	$2,491,622	$2,316,327	$3,032,422	-10%
Physician Assistant (363A00000X)	$577	$86	$4,294	$21,168	$26,466	$38,811	6623%

Eligibility Category (continued)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	5 Year % Change
Physician, General Practice (208D00000X)	$7,598,341	$7,254,319	$7,406,209	$7,372,159	$7,102,893	$6,999,142	-8%
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	$90,174	$85,222	$22,339	$22,049	$16,093	$9,091	-90%
Podiatrist (213E00000X)	$79,404	$72,405	$58,482	$47,751	$42,304	$34,640	-56%
Private Vehicle (347C00000X)		$7,329	$11,145	$18,455	$12,973	$8,702	--
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	$2,934,877	$3,520,283	$3,471,255	$3,693,978	$3,586,650	$2,152,985	-27%
Prosthetic/Orthotic Supplier (335E00000X)	$798,679	$757,241	$615,641	$598,186	$540,444	$610,680	-24%
Psychiatric Hospital (283Q00000X)	$127,648	$75,848	$200,677	$122,776	$21,285	$75,743	-41%
Psychiatric Residential Treatment Facility (323P00000X)	$11,797,657	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	-36%
Psychiatry & Neurology, Neurology (2084N0400X)	$959,006	$805,683	$621,258	$467,204	$333,100	$324,947	-66%
Psychiatry & Neurology, Psychiatry (2084P0800X)	$2,705,413	$2,552,807	$2,270,198	$1,813,284	$1,570,802	$1,855,312	-31%
Psychologist, Clinical (103TC0700X)	$13,790,956	$7,871,344	$5,690,754	$5,179,123	$4,885,196	$3,590,637	-74%
Public Health or Welfare (251K00000X)	$1,072,715	$912,444	$881,179	$917,179	$894,321	$694,400	-35%
Radiology, Diagnostic Radiology (2085R0202X)	$2,018,120	$1,821,704	$1,794,304	$1,677,907	$1,538,606	$1,874,163	-7%
Rehabilitation Hospital (283X00000X)	$1,016,080	$563,688	$562,051	$619,218	$408,441	$567,445	-44%
Residential Treatment Facility, Emotionally Disturbed Children (322D00000X)	$237,904						--
Skilled Nursing Facility (314000000X)	$81,670,473	$86,538,699	$86,684,517	$83,960,515	$88,869,925	$77,813,463	-5%
Social Worker, Clinical (1041C0700X)	$2,284,684	$3,213,974	$3,274,619	$2,962,987	$2,944,114	$2,690,806	18%
Specialist (174400000X)			$61,574	$58,231	$60,043	$56,864	--
Speech-Language Pathologist (235Z00000X)	$714,369	$688,314	$407,957	$242,416	$411,291	$370,827	-48%
Supports Brokerage (251X00000X)	$4,434,368	$3,975,987	$4,570,890	$5,530,177	$6,172,411	$6,977,663	57%
Surgery (208600000X)	$713,150	$740,929	$621,880	$648,362	$502,970	$588,358	-17%
Surgery, Pediatric Surgery (2086S0120X)	$57,200	$76,375	$32,996	$30,182	$33,952	$50,641	-11%
Surgery, Vascular Surgery (2086S0129X)	$32,393	$6,400	$23,257	$14,387	$26,205	$14,120	-56%
Taxi (344600000X)		$16,674	$33,435	$45,135	$36,725	$18,864	--
Technician, Pathology, Phlebotomy (246RP1900X)	$575	--	--	--	--	0	--
Technician/Technologist, Optician (156FX1800X)	$80,235	$68,054	$56,048	$57,048	$47,032	$48,565	-39%
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	$34,078	$20,262	$14,046	$27,538	$11,947	$8,685	-75%
Unclassified	$272,435	$292,866	$635,221	$224,355	$40,885	$89,626	-67%
Urology (208800000X)	$441,176	$295,664	$303,965	$268,132	$235,121	$251,901	-43%
Total	**$554,583,138**	**$556,278,314**	**$567,841,855**	**$554,224,838**	**$544,276,977**	**$566,889,365**	**2%**

APPENDIX B: REIMBURSEMENT METHODOLOGY

This section provides a brief overview and recent history of the reimbursement methodology for the service areas discussed in this report.

Table 69. Reimbursement Methodology and History by Service Area

Ambulance

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Fixed fee schedule for transport
Mileage and disposable supplies reimbursed separately
Separate fee schedules for: Basic life support (ground), Advanced life support (ground), Additional advanced life support (ground), Air ambulance

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Wyoming State Rule Chapter 15; Chapter 3

Ambulatory Surgery Center

Based on Medicaid's Outpatient Prospective Payment System (OPPS). Uses Medicare's relative weights and the Wyoming Medicaid payment method for each service (OPPS status indicator) for each procedure code. Medicaid adopted Medicare's OPPS status indicators for most services, with some adjustments for Medicaid policies.

Services are paid based on one of the following (by status indicator): 1) Ambulatory Payment Classification (APC) fee schedule, 2) separate Medicaid fee schedule, or 3) percentage of charges.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Adjusted conversion factors effective calendar year 2017	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

43 CFR 447.321 SPA 4.19B

Behavioral Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Separate fee schedules based on the type of provider

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Reimbursement rate reduced by 3.3%	No change	Psychologists paid 100% of fee schedule. APRN paid 90% of fee schedule (eff. 1/1/2018)	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

State plan 4.19B

Care Management Entity

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Beginning of service	No change	No change	Payment is made to the CME under a non-risk capitated payment methodology for administrative services. Payment is made to the CME network providers based on a procedure code fee schedule after prior authorization from the CME.	No change	Beginning 10/01/2020, the CME sends a 278 transaction to Conduent. Conduent uses the 278 file to issue PA numbers for services provided by the CME network providers who utilize the PA's to bill the Medicaid fiscal agent directly. Magellan continues to send an 837P to Conduent for the PMPM payments but doesn't submit FFS claims on behalf of the CME network providers since the change on 10/01/2020.

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

Clinic/Center

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	hanged from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Also became part of the Cap Limit process, effective the same date.	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Dental

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Adult optional dental services added (effective July 1, 2006)

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Per Governor's budget cuts, adult dental coverage reduced to preventive and emergency services only.	No change.	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Wyoming State Plan Attachment 4.19B

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Lower of the Medicaid fee schedule, or the provider's usual and customary charge
Rates based on Medicare's fee schedule which is updated annually for inflation based on the consumer price index
For procedure codes not on Medicare's fee schedule, Medicaid considers other states' rates
Certain DME is manually priced based on the manufacturer's invoice price, plus a 15% add-on, plus shipping and handling
Delivery of DME more than 50 miles roundtrip is reimbursed per mile

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	Codes impacted by the 21st Century CURES Act are set at 100% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Wyoming State Rule Chapter 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c

End-Stage Renal Disease

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Dialysis services reimbursed at a percentage of billed charges

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Dialysis services reimbursed at 9% of billed charges (Effective January 1, 2014)	No change	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

42 CFR Part 413 Subpart H; State Plan 4.19B

Federally Qualified Health Centers

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000.
Based on 100% of a facility's average costs during SFYs 1999 and 2000.
Rates increase annually for inflation based on Medicare Economic Index (MEI) charges

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Rates increased 1.1% based on MEI	Rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased by 1.4%

42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

Home Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Per visit rates based on Medicare's fee schedule

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2020
No change	Prior authorization required starting dates of service 3/1/17 and newer	No change	No change	Prior authorization suspended in March 2020.	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

42 CFR 484 Subpart E

Hospice

Per diem rate based on Medicare's fee schedule
Rates adjust annually based on Medicare's adjustments
Rates for services provided to nursing facility residents are 95% of the nursing facility's per diem rate
Rate for room and board in an inpatient hospice facility not to exceed 50% of the established nursing home room and board rate (effective July 1, 2013)

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Due to Governor's budget reductions, reimbursement was reduced by 2.5% for hospice in nursing home.

42 CFR 418; Wyoming State Statute 42-4-103(a)(xxv)

Hospital Inpatient

Level of Care (LOC) rate per discharge
Per diem rates for rehabilitation with a ventilator and separate rate without a ventilator
Transplant services are reimbursed at 55% of billed charges
Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement

Additional payments:
Inpatient hospitals that serve a disproportionate share of low-income individuals receive disproportionate share hospital (DSH) payments
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change to LOC reimbursement; private hospital UPL implemented	No change	DRG implemented 5/31/19 with an effective date 2/1/19. Private hospital UPL program, DSH, QRA still in place. Rehab claims will be paid outside of DRG	Second year of DRG rates implemented February 1, 2020	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

CFR 447 Subpart C Payment; State Plan 4.19B

Hospital Outpatient

Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system
Three conversion factors based on hospital type: General acute; Critical access; Children's
Separate fee schedules for: Select DME; Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammographies; Laboratory; Corneal tissue, dental and bone marrow transplant services, new medical devices

Additional payments:
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2015): General acute $42.34 Critical access $111.93 Children's $92.71 No change for QRA	Adjusted conversion factors due to budget cuts (effective calendar year 2017): General acute $37.94 Critical access $98.80 Children's $76.34 ASCs $33.39 No change for QRA	Adjusted conversion factors due to budget cuts (effective calendar year 2018): General acute $39.70 Critical access $104.27 Children's $83.92 ASCs $34.94 No change for QRA	Adjusted conversion factors (effective calendar year 2019): General acute $42.53 Critical access $105.89 Children's $88.45 ASCs $37.42 No change for QRA	Adjusted conversion factors (effective calendar year 2020): General acute: $45.79 Critical access: $109.66 Children's: $83.59 ASCs: $40.30	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

CFR 447.321; CFR 447.325; Chapter 33 Rule

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Full cost reimbursement method based on previous year cost reports.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Removed link with Nursing Home rates. Rates now updated annually with full cost coverage.	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 20

Laboratory

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Nursing Facility

Prospective per diem rate with rate components for capital cost, operational cost and direct care costs
Additional reimbursement on a monthly basis for extraordinary needs determined on a per case basis

Additional payments:
Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)
Nursing Facility Gap Payment Program approved in SFY 2017 as a supplemental payment program

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

W.S. 42-4-104 (c); State Plan- 4.19D; Chapter 7 Rule

Physicians and Other Practitioners

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Adjusted conversion factor on November 1, 2016 to reflect a 3.3% reduction on all RBRVS codes	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%. Chiropractic services only allowed for children under EPSDT and clients on Medicare. Dietician service no longer have a threshold limit.

State Plan Amendment 3.1 and 4.19B

Prescription Drugs

New rate structure implemented on April 1, 2017, pays lower of:
1) The National Average Drug Acquisition Cost (NADAC)
2) When no NADAC is available, DHCF substitutes Wholesale Acquisition Cost (WAC) into logic
3) State Maximum Allowable Cost (SMAC)
4) Federal Upper Limit (FUL)
5) Ingredient Cost Submitted
6) Gross Amount Due (GAD)
7) Provider's usual and customary (U&C) charge to the public

Reimbursement for claims that pay at GAD or U&C will not include a dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim. Dispensing fee is $10.65 per claim

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Reimbursement structure changed on April 1, 2017 to be in compliance with the Final Covered Outpatient Drug Rule.	No change	No change	No change	No change

State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Rules, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)

Program for All-Inclusive Care of the Elderly (PACE)

Reimbursement made on a per diem rate, based on an all-inclusive payment methodology
Per diem rates are based on the participant's functional assessment

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Rate increased	Rate increased	Rate decreased for Medicaid-only; increased for dual-Medicare/Medicaid	Rates increased for Medicaid-only; decreased for dual-Medicare/Medicaid	Rate decreased	Program was discontinued January 2021 due to budget cuts.

State Plan Amendment 3.1-A

Psychiatric Residential Treatment Facility

Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

W.S. 42-4-103 (a)(xvi); 42 CFR Part 483 Subpart G; 42 CFR Part 441 Subpart D; State Plan- Attachment 4.19A, pg. 1; Attachment 3.1A, pg. 7; Chapter 40 Rule

Public Health or Welfare

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	Adjusted conversion factor on November 1, 2016 to reflect 3.3% reduction on all RBRVS codes	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Public Health, Federal

Indian Health Service (IHS) encounter rate set annually by IHS.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2019	SFY 2021
No change	No change	No change	HS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations

Public Health Service Act, Sections 321(a) and 322(b); Public Law 83-568; Indian Health Care Improvement Act

Rural Health Center

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000
Based on 100% of a facility's average costs during SFYs 1999 and 2000
Rates increased annually for inflation based on Medicare Economic Index (MEI)

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Rates increased 1.1% based on MEI	Rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased by 1.9% based on MEI	Rates increased by 1.4%

42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

Vision

Lower of the Medicaid fee schedule or the provider's usual and customary charge. The most recent update was in SFY 2006 when the rate for standard frames was increased.
Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.
Optician reimbursement based on a procedure code fee schedule

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	No change	No change	No change	Due to Governor's budget reductions, reimbursement was reduced by 2.5%

State Plan 3.1-A; State Plan 4.19B/6.b

Waivers - Comprehensive and Supports

Implemented in SFY 2014 with reimbursment based on the cost-based reimbursement methodology implemented in SFY 2009, but with the reductions made in SFY 2011 and SFY 2014 applied. The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. Consumers negotiate rates based on their budget amount. For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the participant's assessed needs. The ECC will also review requests for IBA adjustments due to a change in client needs or emergencies.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	3.3% across-the-board rate increase and 3.3% increase to each IBA to be implemented 1/1/17	February 1, 2017, implemented 3.3% rate increase applied retroactively back to July 1, 2016.	Rate increase of 4.2% for all services	In response to the COVID-19 public health emergency, provider rates for some Comprehensive Waiver Services were increased by 12.5%, beginning March 1, 2020. The temporary increase ends September 1, 2020. Services receiving the increase were as follows: Adult Day, Child Habilitation, Community Living, Community Support, Companion, Crisis Intervention, Homemaker, Individual Habilitation Training, Personal Care, Respite, Skilled Nursing, Special Family Habilitation Home. and Supported Employment. Additionally, self-directed budgets were increased by 12.5% for the month of June 2020.	Temporary increase to some services during the COVID PHE ended on September 30th. Rates returned to pre-COVID amounts. Effective February 1, 2021, all rates were decreased by 2.5% as a result of budget reductions.

Required to rebase the rates and conduct rate studies every 2 -4 years per Wyoming Statute Wyo. Stat. § 42-4-120(g)

Waiver - Children's Mental Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Care Management Entity began serving youth July 1, 2015	CMS approved SFY 2017 rates, and SFY2017 claims were adjusted	CMS approved SFY 2018 rates, and SFY2018 claims were adjusted	Changed to non-risk based capitated payment to the CME for administrative services and fee for service payments to the network providers.	No change	No change

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

Waiver - Community Choices

Long-Term Care services are paid lower of the Medicaid fee schedule or the provider's usual and customary (U&C) charge with reimbursement limited to a monthly or yearly cap per person, according to their established care plan.
For Assisted Living services, reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem ratesare based on the participant's functional assessment. Per diem rate includes required personal care, 24-hour supervision and medication assistance up to a monthly or yearly cap. Case management services are reimbursed a separate rate. Participants pay their own room and board.

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
12% increase per rate rebasing project, effective March 1, 2016.	No change	No change	No change	Rates for select direct care services increased in response to COVID-19 public health emergency.	COVID increase continued through SFY2021.

Waiver agreement

Waiver - Pregnant by Choice

The waiver was implemented in SFY 2009 Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this appendix

SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021
No change	No change	No change	Extension application submitted to CMS	No change	Application for Family Planning Waiver Services that was approved 4/7/2020 to cover FPW services through 12/31/2027. CMS will reimburse by a PMPM amount that varies depending on calendar year. For SFY2021 (July 1, 2021 - June 30, 2022), the rate would be $12.10 (7/1/2021-12/31/2021) and $12.65 (1/1/2022-6/30/2022). Expenses beyond the PMPM would be covered at Wyoming Medicaid's expense.

APPENDIX C: ELIGIBILITY REQUIREMENTS AND BENEFITS

Table 70. Income Limits by Eligibility Category

Eligibility Category	CY 2021
Children 0-5	154% FPLs
Children 6-18	133% FPL
Former Foster Care Children, age 19 to 26	No income test
Family Care Adults	Values in Table 73
Pregnant Women	154% FPL
ABD Waivers and institutions	Less than or equal to 300% SSI
SSI and SSI Related Coverage Groups	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	101% to 120% FPL
Qualified Individual	121% to 135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL
Tuberculosis	100% SSI
Employed individuals with disabilities	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	Depends on eligibility group qualified under

Table 71. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	CY 2020				CY 2021			
Family Size		1	2	3	4	1	2	3	4
Family Care Adults		$529	$737	$873	$999	$529	$737	$873	$999
Federal Poverty Level (FPL)	100%	$1,064	$1,437	$1,810	$2,184	$1,074	$1,452	$1,830	$2,209
	133%	$1,415	$1,911	$2,408	$2,904	$1,428	$1,931	$2,434	$2,938
	154%	$1,638	$2,213	$2,788	$3,363	$1,653	$2,236	$2,819	$3,401
Supplementary Security Income (SSI)	100%	$771	$1,157	--	--	$783	$1,175	--	--
	300%	$2,313	$3,471	--	--	$2,349	$3,525	--	--

Table 72. Eligibility Requirements

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Children	Newborn	Full Medicaid Coverage	Newborns up to age one, with Medicaid eligible mothers	N/A; eligibility determined by mother's Medicaid eligibility		
	Children Age 0-5	Full Medicaid Coverage	Under age six	Countable family income	Less than or equal to 154 percent of FPL	
	Children Age 6-18	Full Medicaid Coverage	Under age 19	Countable family income	Less than or equal to 133 percent of FPL	
	Foster Care	Full Medicaid Coverage	Under age 21, in DFS custody	Requirements vary by type of foster care coverage		
	Subsidized Adoption	Full Medicaid Coverage	Under age 18; under age 21 for children with special needs	Requirements vary by type of subsidized adoption		
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
	Presumptive Eligibility for Pregnant Women	Outpatient services for a limited time	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
Family Care	Family Care	Full Medicaid Coverage	Adult with eligible child under age 19 living in the household	Countable family income	Less than or equal to Family Care Income Standard	
	Family Care 4 and 12 month (extended medical)	Full Medicaid Coverage	Adult with eligible child under age 18 living in the household; Family unit must have received family care benefits for at least three of the previous 6 months	Countable family income	Exceeds the family care income standard due to increased income due to increased employment, increased earnings, parent returning to work, or spousal support	
	Former Foster Youth	Full Medicaid Coverage	Under age 26	Client has to have been in DFS (Dept of Family Services) custody and on a Federally Funded Foster Care program at age 18 or older		

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Aged, Blind, or Disabled (ABD)	ABD Individuals in Institutions	Full Medicaid Coverage	Age 65 or older; or blind by SSA standards; or disabled by SSA standards; and in an institutional setting, such as nursing home, IMD, hospice care, inpatient hospital, or ICF-IID	Countable personal income	Less than or equal to 300 percent of the SSI payment standard for a single individual	yes
	Categories with eligibility determined by Social Security Administration (SSA)	Full Medicaid Coverage	SSI eligibility or SSI related eligibility. Goldberg Kelly, 1619, Window Widowers SDX and most DAC cases are all determined by SSA.	Countable personal and spousal income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard	yes
	SSI related categories with eligibility determined by WDH	Full Medicaid Coverage	Lost SSI due to increase or receipt of Social Security benefits; disregard increase or SSA benefit amount	Countable personal income	Countable income less than or equal to Monthly SSI Payment Standard	yes
Medicare Savings Program	Qualified Medicare Beneficiary (QMB)	• Medicaid covers Medicare Part A/B premiums • CMS may assist with Medicare Part D premiums • Medical deductible and coinsurance payments	Entitled to Medicare Part A or Part B	Countable personal and spousal income	Less than or equal to 100 percent of FPL	yes
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays Medicare Part B premiums	Entitled to Medicare Part B	Countable personal and spousal income	Between 101 and 120 percent of FPL	yes
	Qualified Individuals (QI	Medicaid pays Medicare Part B premiums (100% federal funds)	Entitled to Medicare Part B	Countable personal and spousal income	Between 121 and 135 percent of FPL	yes

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Special Groups	Breast and Cervical Cancer	Full Medicaid Coverage	Between age 18 and 65 (if over 65, must not be eligible for Medicare Part B); meet the Cancer and Chronic Disease Prevention unit criteria; no insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B)	Countable personal income	Less than or equal to 250 percent of FPL	
	Tuberculosis	Partial benefits related to tuberculosis	Verification of tuberculosis	Countable personal income	SSI Payment Standard	yes
Medicaid Buy-In	Employed Individuals with Disabilities	Full Medicaid benefits after payment of premium (7.5 percent of gross monthly income)	Between age 16 and 64; disabled; employed	Countable personal income	Unearned income less than or equal to 300 percent of the SSI standard for a single individual, no limit on earned income	
Non-Citizens	Non-Citizens with Medical Emergencies	Benefits limited to services provided from the time treatment was given for a condition until that same condition is no longer considered an emergency	Illegal immigrants or qualified immigrants who do not meet citizenship criteria. Eligibility must be determined monthly.	Meets applicable eligibility requirements under an existing eligibility group		

APPENDIX D: GLOSSARY & ACRONYMS

GLOSSARY

Acquired Brain Injury (ABI) – Damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder.

Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act as well as the Healthcare and Education Reconciliation Act was signed into law in March 2010. These laws are collectively known as the Affordable Care Act legislation and represent a significant overhaul to the healthcare system.

Ambulatory Surgical Center (ASC) – A free-standing facility, other than a physician's office or a hospital, where surgical and diagnostic services are provided on an ambulatory basis. The facility operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours.

Ambulatory Payment Classifications (APC) – A group to which an outpatient service is assigned in Medicare's prospective payment system for outpatient hospital services. The healthcare common procedure coding system, including certain current procedural terminology codes and descriptors are used to identify and group the services within each APC group. Services within an APC group are comparable clinically and with respect to resource use. A payment rate is established for each APC group.

American Recovery and Reinvestment Act of 2009 (ARRA) – Legislation signed into law in February 2009 in response to the economic crisis. The Act specified funding for a wide range of federal programs, including certain benefits under Medicaid.

Average Wholesale Price (AWP) – The published price for drug products charged by wholesalers to pharmacies.

Basic Life Support – A level of medical care, usually provided by emergency medical service professionals, provided to patients of life-threatening illnesses or injuries until they can be given full medical care. Basic life support consists of essential non-invasive life-saving procedures including CPR, bleeding control, splinting broken bones, artificial ventilation, and basic airway management.

Benefits Improvement and Protection Act of 2000 (BIPA) – Legislation signed into law in December 2000 that affects several aspects of Medicare and Medicaid.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the Department of Health and Human Services that administers the Medicare program, and works with states to administer Medicaid. In addition to Medicare and Medicaid, CMS oversees the Children's Health Insurance Program.

Children's Health Insurance Program (CHIP) – A federal-state partnership program to provide free or low-cost health insurance for uninsured children under age 19. The CHIP is intended for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

Cognos – The reporting tool used to extract data from the Medicaid Management Information System (MMIS).

Commission on Accreditation of Rehabilitation Facilities (CARF) – An organization that accredits rehabilitation facilities.

Community Mental Health Center (CMHC) – A community based healthcare facility that provides comprehensive mental health services to individuals residing or employed in the facility service area.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that provides coordinated, comprehensive outpatient rehabilitation services under the supervision of a physician. At minimum, a CORF must provide physician supervision and physical therapy and social or psychological services to be certified as a CORF.

Co-payment – A fixed amount of money paid by the enrolled member at the time of service.
Council on Accreditation – An organization that accredits healthcare organizations.
Crossover Claim – Services for Medicaid and Medicare dual individuals in which Medicare is the primary payer and forwards the claim to Medicaid for additional payments.

Current Procedural Terminology (CPT) – A code set developed by the American Medical Association for standardizing the terminology and coding used to report medical procedures and services. CPT codes are Level I of the HCPCS code set.

Deficit Reduction Act of 2005 (DRA) – Legislation signed into law in February 2006 that affects several aspects of Medicare and Medicaid.

Department of Health and Human Services (HHS) – The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Disproportionate Share Hospital (DSH) – Hospitals that serve a significantly disproportionate number of low-income individuals. Eligible hospitals can receive an adjustment payment under Medicaid.

Drug Utilization Review (DUR) – A review utilization of outpatient prescription drugs to determine if recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects.

Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies – Medical equipment and other supplies that are intended to reduce an individual's physical disability and restore the individual to his or her functional level.

Dual Individual – For the purposes of this Report, an individual enrolled in Medicare and Medicaid who is eligible to receive Medicaid services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – The comprehensive and preventive child health component of Medicaid for individuals under age 21. Medicaid's EPSDT services are operated under the Health Check program. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

Eligibility – Criteria that establish an individual as qualified to enroll in Medicaid. The federal government establishes minimum eligibility standards and requires states to cover certain population groups. States have the flexibility to cover other population groups within federal guidelines.

Enrollment – A unique count of members enrolled in Medicaid. Enrollment may be reported at a point in time (e.g., as of June 30) or over a time frame (e.g., SFY 2015).

End-Stage Renal Disease (ESRD) – The complete, or almost complete, failure of the kidneys to function. The only treatments for ESRD are dialysis or kidney transplantation.

Estimated Acquisition Cost (EAC) – The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug.

Expenditure – Funds or money spent to liquidate an expense regardless of when the service was provided or the expense was incurred.

Explanation of Benefits (EOB) – An itemized statement of services from an insurance company detailing what services were paid for on the behalf of an individual. The EOB informs an individual what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.

Federal Fiscal Year (FFY) – The 12 month accounting period, for which the federal government plans its budget, usually running from October 1 through September 30. The FFY is named for the end date of the year (e.g., FFY 2009 ends on September 30, 2009).

Federal Medical Assistance Percentage (FMAP) – The percentage rates used to determine the federal matching funds allocated to the Medicaid program. The FMAP is the portion of the Medicaid program that is paid by the federal government.

Federal Upper Limit (FUL) – The maximum price pharmacies receive as reimbursement for providing multiple-source generic prescription drugs. The FUL is established by the Centers for Medicare and Medicaid Services in order to achieve savings by taking advantage of current market pricing. Not all drugs have FULs and states may establish reimbursement limits for non-FUL drugs using other pricing methodologies.

Fee Schedule – A complete listing of fees used by health plans to pay medical care professionals.

Healthcare Common Procedure Coding System (HCPCS) – A standardized coding system used to report procedures, specific items, equipment, supplies, and services provided in the delivery of healthcare. There are two principal subsystems, Level I and Level II. Level I codes are comprised of CPT codes which are identified by five numeric digits. Level II codes are used primarily to identify equipment, supplies and services not included in the CPT code set. Level II codes are alphanumeric codes.

Home and Community Based Services (HCBS) – Care provided in the home and community to individuals eligible for Medicaid. The HCBS programs help the elderly and disabled, intellectually disabled, developmentally disabled and certain other disabled adults.

HCBS Acquired Brain Injury (ABI) Waiver – A HCBS waiver developed to assist adults from ages 21 to 65 with acquired brain injuries to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Being replaced by the Comprehensive and Supports Waiver starting in SFY 2016.

HCBS Assisted Living Facility (ALF) Waiver – A HCBS waiver that allows participants ages 19 and older who require services equivalent to a nursing facility level of care to receive services in an ALF. This waiver closed in SFY 2017, with service now provided under the Community Choices Waiver.

HCBS Adult Developmental Disabilities (DD) Waiver – A HCBS waiver developed to assist adults with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

HCBS Child Developmental Disabilities (DD) Waiver – A HCBS waiver developed to assist children under age 21 with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

HCBS Children's Mental Health (CMH) Waiver – A HCBS waiver developed to allow youth with serious emotional disturbances who need mental health treatment to remain in their home communities.

HCBS Community Choices (CC) Waiver – A HCBS waiver allowing participants age 19 and older who require services equivalent to a nursing facility level of care to receive services in an assisted living facility or in their home.

HCBS Comprehensive Waiver – A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability.

HCBS Long-Term Care (LTC) Waiver – A HCBS waiver that provides in-home services to participants ages 19 and older who require services equivalent to a nursing facility level of care. Replaced by the Community Choices Waiver in SFY 2017.

HCBS Supports Waiver - A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability. Provides more flexible service than the Comprehensive Waiver, but with a lower cap on benefits.

Health Professional Shortage Area (HPSA) – A geographic, demographic or institutional designation by the Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) – A facility that primarily provides comprehensive and individualized healthcare and rehabilitation services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

Individualized Budget Amount (IBA) – In the developmental disability and acquired brain injury waiver programs, the amount of funding allocated to each participant based on individual characteristics and his or her service utilization.

Joint Commission – An organization that accredits healthcare organizations.

Level of Care (LOC) – Medicaid's prospective payment system for inpatient hospital services. Medicaid reimburses an amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedure, or revenue codes that hospitals report on the

inpatient claim.

Medicaid – A joint federal-state program authorized by Title XIX of the Social Security Act that provides medical coverage for certain low-income and other categorically related individuals who meet eligibility requirements. A portion of the Medicaid program is funded by the federal government using the Federal Medical Assistance Percentage.

Medicaid Management Information System (MMIS) – An integrated group of procedures and computer processing operations (subsystems) that supports the Medicaid program operations. The functional areas of the MMIS include recipients, providers, claims processing, reference files, surveillance and utilization review, management and administration reporting, and third-party liability. The MMIS is certified by the Centers for Medicare and Medicaid Services.

Medicare – A federal program, authorized by Title XVIII of the Social Security Act, that provides medical coverage for individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals of all ages with end-stage renal disease.

Medicare Economic Index (MEI) – An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule. Medicaid uses the index as an update factor for FQHC and RHC reimbursement rates.

Member – An individual enrolled in Medicaid and eligible to receive services.

Modified Adjusted Gross Income (MAGI) — A new income methodology implemented in SFY 2013.

Per Member per Month – The monthly average cost for each enrolled member.

Pharmacy Benefit Management (or Manager) (PBM) – Third-party administrator of prescription drug programs.

Preferred Drug List (PDL) – A list of clinically sound and cost-effective prescription drugs covered by Medicaid that do not require prior authorization.

Pregnant by Choice Waiver – A Section 1115 waiver that provides family planning services and birth control options to women who have received Medicaid benefits under the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth.

Prescription Drug Assistance Program (PDAP) – A state-funded program administered by the Healthcare Financing Division providing up to three prescriptions per month to Wyoming residents with income at or below 100 percent of the FPL.

Prior Authorization (PA) – The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.

Procedure Code – A HCPCS Level I or Level II code used to report the delivery of healthcare for reimbursement purposes.

Psychiatric Residential Treatment Facility (PRTF) – A facility that provides services to individuals who require extended care beyond acute psychiatric stabilization or extended psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter-term care.

Qualified Rate Adjustment (QRA) – Medicaid's annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. The QRA payments are only available to in-state hospitals for inpatient and outpatient services.

Recipient – For the purposes of this Report, an individual enrolled in Medicaid who received Medicaid services.

Resource Based Relative Value Scale (RBRVS) – Established as part of the Omnibus Reconciliation Act of 1989, Medicare's payment principles for physician services were adjusted by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a conversion factor. Procedures are assigned a relative value which is adjusted by geographic region. This value is then multiplied by a conversion factor to determine the amount of payment.

Rural Health Clinic (RHC) – A designated health clinic in a medically under-served area that is non-urbanized as defined by the U.S. Bureau of Census and that is eligible to receive cost-based Medicare and Medicaid reimbursement.

Section 1115 Waiver – An experimental, pilot or demonstration project authorized by Section 1115 of the Social Security Act. Section 1115 projects allow states the flexibility to test new or existing approaches to financing and delivering the Medicaid program.

Social Security Act – The legislation, signed in 1965 that authorized Medicare under Title XVIII, and Medicaid under Title XIX.

State Fiscal Year (SFY) – The 12 month accounting period for which the state plans its budget, usually running from July 1 through June 30. The SFY is named for the end date of the year (e.g., SFY 2009 ends on June 30, 2009).

State Funds – For the purposes of this Report, funds that do not receive any Medicaid Federal Medical Assistance Percentage.

State Maximum Allowable Cost (SMAC) – The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic prescription drugs. Medicaid may include more drugs than what are covered under the federal upper limit program as well as set reimbursement rates that are lower than federal upper limit rates.

Supplemental Security Income (SSI) – A federal income supplement program administered by the Social Security Administration. It is designed to assist the aged, blind, or disabled individuals who have little or no income and provides cash to meet basic needs for food, clothing and shelter.

Third-Party Liability (TPL) – The legal obligation of a third party to pay part or all of the expenditures for medical assistance under Medicaid.

Usual and Customary Charge – The fee that is most consistently charged by a healthcare provider for a particular procedure. The actual price that pharmacies charge cash-paying customers for prescription drugs.

ACRONYMS

Table 73. Acronyms

Acronym	Meaning	Acronym	Meaning
ABD	Aged, Blind, or Disabled	ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ABI	Acquired Brain Injury	LEP	Limited English Proficiency
ACA	Affordable Care Act	LOC	Level of Care
ALF	Assisted Living Facility	LTC	Long-Term Care
APC	Ambulatory Payment Classification	MAGI	Modified Adjusted Gross Income
ARRA	American Recovery and Reinvestment Act of 2009	MEI	Medicare Economic Index
ASC	Ambulatory Surgery Center	MFCU	Medicaid Fraud Control Unit
AWP	Average Wholesale Price	MMIS	Medicaid Management Information System
BHD	Behavioral Health Division	MU	Meaningful Use
BIPA	Benefits Improvement and Protection Act of 2000	NAMFCU	National Association of Medicaid Fraud Control Units
CARF	Commission on Accreditation of Rehabilitation Facilities	NPI	National Provider Identifier
CCD	Continuity of Care Document	OIG	Office of Inspector General
CHIP	Children's Health Insurance Program	OPPS	Outpatient Prospective Payment System
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009	OSCR	On-Site Compliance Review
CME	Care Management Entity	P&T	Pharmacy and Therapeutics
CMHC	Community Mental Health Center	PA	Prior Authorization

Acronym	Meaning	Acronym	Meaning
CMS	Centers for Medicare and Medicaid Services	PAB	Psychiatrist Advisory Board
COA	Council on Accreditation of Services for Families and Children	PACE	Program of All-Inclusive Care for the Elderly
CORF	Comprehensive Outpatient Rehabilitation Facility	PBM	Pharmacy Benefit Management (or Manager)
CPT	Current Procedural Terminology	PCMH	Patient-Centered Medical Home
CQM	Clinical Quality Measures	PDAP	Prescription Drug Assistance Program
DD	Developmental Disabilities	PDL	Preferred Drug List
DFS	Department of Family Services	PMPM	Per Member Per Month
DME	Durable Medical Equipment	POS	Prosthetics, Orthotics and Supplies
DRA	Deficit Reduction Act	PPS	Prospective Payment System
DSH	Disproportionate Share Hospital	PRTF	Psychiatric Residential Treatment Facility
DUR	Drug Utilization Review	QIS	Quality Improvement Strategy
EAC	Estimated Acquisition Cost	QMB	Qualified Medicare Beneficiaries
EHR	Electronic Health Record	QRA	Qualified Rate Adjustment
EOB	Explanation of Benefits	RBRVS	Resource Based Relative Value Scale
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment	RHC	Rural Health Clinic
ESRD	End-Stage Renal Disease	RIBN	Resource Integration into Behavioral Health Networks
FFY	Federal Fiscal Year	SCHIP	State Children's Health Insurance Program
FMAP	Federal Medical Assistance Percentage	SFY	State Fiscal Year
FPL	Federal Poverty Level	SLMB	Specified Low-Income Medicare Beneficiaries
FQHC	Federally Qualified Health Center	SMAC	State Maximum Allowable Cost
FUL	Federal Upper Limit	SSA	Social Security Administration
HCBS	Home and Community Based Services	SSDC	Sovereign States Drug Consortium
HCPCS	Healthcare Common Procedure Coding System	SSI	Supplemental Security Income
HHS	Department of Health and Human Services	TB	Tuberculosis
HIE	Health Information Exchange	THR	Total Health Record
HIT	Health Information Technology	TPL	Third-Party Liability
HPSA	Health Professional Shortage Area	WDH	Wyoming Department of Health
IBA	Individualized Budget Amount	WES	Wyoming Eligibility System

APPENDIX E: DATA METHODOLOGY

ENROLLMENT

- A member is any individual enrolled in Medicaid, identified by a Medicaid ID number
- Enrollment is a distinct count of Medicaid members based on ID number
- Members are enrolled in an eligibility program code, which define the eligibility categories
- See tables for the eligibility category breakdown by program codes
- Monthly average of enrollment is calculated using the distinct count of members as of the last day of each month
- Total SFY enrollment is a distinct count of all members enrolled at any time during the SFY, regardless of the duration of their enrollment span

RECIPIENTS

- A recipient is any enrolled member who has received services and had a Medicaid claim processed and paid during the SFY
- Since the distinct count of recipients is based on claims paid during the SFY, this count may exceed enrollment as some recipients may not have maintained enrollment in the SFY in which their claim paid

EXPENDITURES

- Expenditures represent claim payments made to providers during the SFY.
- For this report, expenditures includes all paid claims, including those that were adjusted and re-adjusted during the SFY.
- Third-party payments, co-payments, DSH payments, and history-only adjustments are excluded from totals, as are premium and cost-sharing assistance for Medicare individuals

PER MEMBER PER MONTH

- The Per Member Per Month (PMPM) represents the monthly average cost for each enrolled member.
- The calculation is equal to expenditures divided by member months in which expenditures are based on original and final adjusted claims by first service dates and member months is the sum of the number of months individuals are enrolled in Medicaid.
- The PMPM value in this report is a preliminary value only.
- The final SFY 2020 PMPM value will be available in the separate Wyoming Medicaid Per Member Per Month report.

SERVICES

- Most service areas are defined using pay-to-provider taxonomy codes on claims paid during the SFY. See table 77 for the parameters used for each service and special population in this report.
- Other services may use claim types or the recipient's eligibility program code in addition to the pay-to-provider tax code.

Table 74. Medicaid Chart A Eligibility Program Codes

Eligibility Category	Program Codes	
Aged, Blind, Disabled Employed Individuals with Disabilities	S56	Emp Ind w/ Disabilities > 21
	S57	Emp Ind w/ Disabilities < 21
	S61	Continuous EID <19
Aged, Blind, Disabled Intellectual/ Developmental Disabilities and Acquired Brain Injury	B01	Acq Brain Injury Wvr SSI
	B02	Acq Brain Injury Wvr 300%
	S60	Acq Brain Injury Wvr w/ EID <65
	S22	DD Waiver SSI > 65 (inactive)
	S23	DD Waiver 300% Cap > 65 (inactive)
	S44	DD Wvr SSI Between 21 & 65 Yrs (inactive)
	S45	DD Wvr 300% Between 21 & 65 Yrs (inactive)
	S59	DD Waiver w/ EID > 21 (inactive)
	S58	DD Waiver w/ EID < 21 (inactive)
	S65	Continuous DD < 19 (inactive)
	S93	DD Waiver SSI <21 (inactive)
	S94	DD Waiver 300% Cap <21 (inactive)
	W03	EID Comp Waiver Adult > 21
	W08	SSI Comp Waiver Adult > 21
	W10	SSI Comp Waiver Aged > 65
	W14	300% Comp Waiver Adult > 21
	W16	300% Comp Waiver Aged > 65
	W04	EID Comp Waiver Child < 21
	W09	SSI Comp Waiver Child < 21
	W15	300% Comp Waiver Child < 21
	W22	EID Comp ABI Waiver Adult > 21
	W23	SSI Comp ABI Waiver Adult > 21
	W24	SSI Comp ABI Waiver Aged > 65
	W25	300% Comp ABI Waiver Adult > 21
	W26	300% Comp ABI Waiver Aged > 65
	S03	ICF-MR SSI > 65
	S04	ICF-MR 300% Cap > 65
	S05	ICF-MR SSI < 65
	S06	ICF-MR 300% Cap < 65
	W01	EID Support Waiver Adult > 21
	W05	SSI Support Waiver Adult > 21
	W07	SSI Support Waiver Aged > 65
	W11	300% Support Waiver Adult > 21
	W13	300% Support Waiver Aged > 65
	W02	EID Support Waiver Child < 21
	W06	SSI Support Waiver Child < 21
	W12	300% Support Waiver Child < 21
	W17	EID Support ABI Waiver Adult > 21

Eligibility Category (continued)	Program Codes	
Aged, Blind, Disabled Intellectual/ Developmental Disabilities and Acquired Brain Injury (continued)	W18	SSI Support ABI Waiver Adult > 21
	W19	SSI Support ABI Waiver Aged > 65
	W20	300% Support ABI Waiver Adult > 21
	W21	300% Support ABI Waiver Aged > 65
Aged, Blind, Disabled Institution	S14	Institutional (Hosp) Aged - Inactive
	S15	Inpatient Hospital 300% Cap > 65
	S34	Institutional (Hosp) Disabled - Inactive
	S35	Inpatient Hospital 300% Cap < 65
	S13	Inpat-Psych > 65
Aged, Blind, Disabled Long-Term Care	R01	Asst Living Fac Wvr SSI < 65
	R02	Asst Living Fac Wvr 300% < 65
	R03	Asst Living Fac Wvr SSI > 65
	R04	Asst Living Fac Wvr 300% > 65
	S50	Hospice Care > 65
	S51	Hospice Care < 65
	N98	WLTC Temp Services
	S24	LTC Waiver SSI > 65
	S25	LTC Waiver 300% Cap > 65
	S46	LTC Waiver SSI < 65
	S47	LTC Waiver 300% Cap < 65
	N97	NH Temp Services
	S01	NH-SSI & Ssa Blend >65
	S02	NH-SSI & Ssa Blend <65
	S10	Nursing Home SSI >65
	S11	Nursing Home 300% Cap >65
	S17	Retro Medicaid-"Pr" Aged (inactive)
	S18	Retro Medicaid-"Rm" Aged (inactive)
	S30	Retro Medicaid-"Pr" Disabled (inactive)
	S32	Nursing Home SSI <65
	S33	Nursing Home 300% Cap <65
	S54	Medicaid Only-No Rm & Brd >65
	S55	Medicaid Only-No Rm & Brd <65
	S90	Retro Medicaid-"Rm" Disabled
	P11	PACE < 65
	P12	PCMR < 65
	P13	PACE SSI Disabled < 65
	P14	PACE Mcare SSI Disabled < 65
	P15	PACE NF < 65
	P16	PACE NF SSI Disabled < 65
	P17	PACE NF Mcare Disabled < 65
	P18	PACE NF Mcare SSI Disable < 65
	P21	PACE > 65
	P22	PCMR > 65

Eligibility Category (continued)	Program Codes	
Aged, Blind, Disabled Long-Term Care (continued)	P23	PACE SSI Aged > 65
	P24	PACE Mcare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
	P28	PACE NF Mcare SSI Aged > 65
Aged, Blind, Disabled SSI & SSI Related	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Pymt
	S31	SSI Eligible <65
	S36	Disabled Adult Child (DAC)
	S37	Goldberg-Kelly
	S39	1619 Disabled
	S40	Aptd Essent. Person Med Only -I
	S48	Zebley >21
	S49	Zebley <21
	S92	Widow-Widowers SDX
	S98	Pseudo SSI Aged (inactive)
	S99	Pseudo SSI Disabled (inactive)
	S09	SSI-Disabled Child Definition
	S16	Pickle >65
	S38	Pickle <65
	S42	Widow-Widowers
	S43	Qual Disabled Working Ind

Eligibility Category (continued)	Program Codes	
Children	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
	A50	AFDC Medicaid (inactive)
	A54	2nd-6mos. Trans Mcaid Child (inactive)
	A56	Alien: 245 (IRCA) Child (inactive)
	A57	Baby <1 Yr, Mother SSI Elig (inactive)
	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont Childrens Ment Health Wvr < 19
	S95	Childrens Ment Hlth Wvr SSI < 21
	S96	Childrens Ment Hlth Wvr 300% <21
	A51	IV-E Foster Care
	A52	IV-E Adoption
	A85	Foster Care Title 19
	A86	Subsidized Adoption Title 19
	A88	Aging Out Foster Care
	A97	Foster Care 0 Through 5
	A98	Foster Care 6 Through 18
	M09	Former Foster Youth <21
	M17	Former Foster Youth PE <21
	S63	Continuous Foster Care <19
	A53	Newborn

Eligibility Category (continued)	Program Codes	
Medicare Savings Programs	Q17	QMB > 65
	Q41	QMB < 65
	Q66	QMB Dual with Full Medicaid
	Q94	SLMB 2 > 65
	Q95	SLMB 2 < 65
	Q96	SLMB 1 > 65
	Q97	SLMB 1 < 65
	Q67	SLMB Dual with Full Medicaid
	Q98	Part B-Partial Aged (Inactive)
	Q99	Part B-Partial Disabled (Inactive)
Non-Citizens with Medical Emergencies	A81	Emergency Svc < 21
	A84	Emergency Svc > 21
Pregnant Women	A71	Pregnant Woman < 21
	A72	Pregnant Woman > 21
	A73	Qualified Pregnant Woman > 21
	A74	Qualified Pregnant Woman < 21
	M06	Pregnancy MAGI > 21
	M07	Pregnancy MAGI < 21
	A19	Presumptive Eligibility
Special Groups	B03	Breast & Cervical > 21
	B04	Breast & Cervical < 21
	M15	Breast & Cervical PE > 21
	M16	Breast & Cervical PE < 21
	S52	Tuberculosis (Tb) > 65
	S53	Tuberculosis (Tb) < 65
	A20	Pregnant By Choice
Screenings & Gross Adjustments	N96	Disability Determination Only
	N99	LTC Screening Only
	W99	Single Day Waiver Assessment
	S97	CASII Screening Only
	ZZZ	Other
	P07	CHIPRA CME

Table 75. Medicaid Chart B Eligibility Program Codes

Eligibility Category	Program Codes	
State Funded Foster Care	A95	Pending Foster Care
	A96	Basic Foster Care
	A99	Institutional Foster Care
Project Out	P05	Project Out Transitional Coverage

DATA PARAMETERS

As stated in the previous section, Expenditures are calculated using all Medicaid Chart A recipient program codes and all claim adjustments except history-only adjustments. Counts exclude several program codes and only include original and final claims.

Table 76. Data Parameters by Service Area

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Ambulance - Total	341600000X	Ambulance	n/a
Ambulance - Air	341600000X	Ambulance	Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998
Ambulance - Ground	341600000X	Ambulance	Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998
Ambulatory Surgery Center	261QA1903X	Ambulatory Surgery Center	n/a
Behavioral Health	101Y00000X 101YA0400X 101YP2500X 103G00000X 103K00000X 103TC0700X 1041C0700X 106E00000X 106H00000X 106S00000X 163W00000X 164W00000X 171M00000X 172V00000X 2084P0800X 261QM0801X 261QR0405X 364SP0808X	Professional Counselor; Certified Mental Health Worker Addictions Therapist/Practitioner Professional Counselor Neuropsychologist Behavior Analyst Clinical Psychologist Social Worker Assistant Behavior Analyst Marriage and Family Therapist Behavior Technician RN LPN Case Worker Community Health Worker; Peer Specialist; Certified Addictions Practitioner Assistant Psychiatrist Mental Health - including Community Mental Health Center Rehabilitation, Substance Use Disorder NP, APN Psychiatric/Mental Health	n/a
Behavioral Health services provided by Non BH providers	EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal		Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125 99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider Claim Types: EXCLUDE W (waiver)
Care Management Entity	251S00000X	CHPR CME	n/a

Service Area (continued)	Pay-to-Provider Taxonomy		Other Parameters
Clinic/Center	261Q00000X	Clinic/Center	n/a
Dental	122300000X 1223D0001X 1223E0200X 1223G0001X 1223P0221X 1223P0300X 1223S0112X 1223X0400X	Dentist Dental Public Health Endodontics General Practice Dentist Pedodontics Periodontics Surgery, Oral and Maxillofacial Orthodontics	n/a
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	332B00000X 332S00000X 335E00000X	DME Hearing Aid Equipment POS	n/a
Durable Medical Equipment Only	332B00000X 332S00000X	DME Hearing Aid Equipment	n/a
Prosthetics, Orthotics, and Supplies Only	335E00000X	POS	n/a
End-Stage Renal Disease	261QE0700X	End-Stage Renal Disease	n/a
Federally Qualified Health Center	261QF0400X	Federally Qualified Health Center	n/a
Home Health	251E00000X	Home Health	n/a
Hospice	251G00000X	Hospice Care, Community Based	n/a
Hospital Total	261QR0400X 282N00000X 282NR1301X 283Q00000X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	n/a
Hospital Inpatient	282N00000X 282NR1301X 283Q00000X 283X00000X	General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	Claim Type: I, X
Hospital Outpatient	261QR0400X 282N00000X 282NR1301X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Rehabilitation Hospital	Claim Type: O, V
Hospital Emergency Room	All Taxonomies		Procedure Codes: 99281 thru 99285 OR Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (2020 HEDIS) OR Revenue Code: 0450 through 0459 Counts: Claim Type O Expenditures: Header level amounts for all events that have both Medical and Outpatient claim (i.e. no associated inpatient admission)
International Care Facility for Individuals with Intellectual Disabilities	315P00000X	Intermediate Care Facility, Intellectual Disability	n/a
Laboratory	291U00000X	Clinical Medical Laboratory	n/a

Service Area (continued)	Pay-to-Provider Taxonomy		Other Parameters
Nursing Facility	275N00000X 314000000X	Medicare Defined Swing Bed Skilled Nursing Facility	n/a
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a
Physician and Other Practitioner Total	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X 225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	 Psychiatrists Physician Assistant Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Physician	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X	 Psychiatrists Physician Assistant	n/a
Other Practitioner	225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Prescription Drug	333600000X	Pharmacy	Claim Type: P
Psychiatric Residential Treatment Facility	323P00000X	Psychiatric Residential Treatment Facility	Claim Types: I, X
Public Health, Federal	261QP0904X	Public Health, Federal	n/a
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a
Vision	152W00000X 156FX1800X	Optometrist Optician	n/a

Service Area (continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - HCBS Waivers - Waiver Only Services	251B00000X 251C00000X 251X00000X	Case Management Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - HCBS Waivers - Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X, 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - Acquired Brain Injury Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60
Waiver - Acquired Brain Injury Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60
Waiver - Adult with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Adult with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Child with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S58, S93, S94, S64

Service Area (continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Child with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S95, S96, S65
Waiver - Children's Mental Health Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S95, S96, S65
Waiver Comprehensive Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver Comprehensive Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver - Community Choices Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04
Waiver - Community Choices Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04
Waiver - Pregnant by Choice	All Taxonomies		Recipient Program Code: A20
Waiver - Supports Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21
Waiver - Supports Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21

Table 77. Data Parameters for Subprogram and Special Populations

Subprogram / Special Population	Parameters
Crossover Claims	Claim Type: B, V, X
Foster Care - Medicaid	Recipient Program Codes: A51, A52, A85, A86, A88, A97, A98, S63
Foster Care - State Funded	Recipient Program Codes: A95, A96, A99
Project Out	Procedure Codes S5165, T2038, T1017, S9986 and Pay to Provider Taxonomy 251B00000X